



Patient Name: (Last) (First) Date:

Date of Birth: / / Age: Female: Male:

Referred by:

Please fill out the below questions:

1. When did you first become aware of your tinnitus?

2. When did your tinnitus first become disturbing?

3. In which ear is your tinnitus (right, left, both, not in the ears, in the head, worse R, worse L)?

4. Is your tinnitus constant or intermittent?

5. What does your tinnitus sound like (for example, ringing, crickets, humming, etc)?

6. Does your tinnitus fluctuate in intensity or loudness?

Is it a pulsing sound that changes in time with your heartbeat?

7. What seems to make the tinnitus?

8. Is it make worse by exposure to a sound? If so, how long does it stay bad after sound exposure?

9. List all methods, procedures, medications or devices you have tried for your tinnitus, and the treatment outcomes?

(Include additional sheet if you want)

10. Have you seen ear specialists about your tinnitus? How many?

What were you told?

Tinnitus Hyperacusis Continued



11. Do you have a hearing loss? If so, please describe:

12. Do you wear a hearing aid(s)?

13. If you have hyperacusis (hypersensitivity to loud sounds), when were you first aware of this problem?

14. Are you uncomfortable around certain sounds?

15. Do you wear ear protection (plugs or muffs)?

16. Do you wear ear protection in quiet situations?

17. Do you experience pain in the ears from loud sounds

18. Do you have loose dentures, jaw pain or grinding or clicking sensations in your jaw?

19. Have you ever worked anywhere that exposed you to continuous loud noise?

20. Estimate the percentage of time over the past month that you have been aware of the tinnitus?

21. Estimate the percentage of time over a month period (not counting sleeping) when you are:

a). In a quiet environment (e.g., quiet home; you can be understood even when speaking softly) %

b). Moderate environment (e.g., average street, office, restaurant) %

c). Loud environment (noisy work place, very loud radio or TV) %

22. Are there activities that you are prevented from doing, or that are affected by the tinnitus/hyperacusis?



| ACTIVITY | TINNITUS (Circle one) | HYPERACUSIS (Circle one) |
|----------------------------------|------------------------------|---------------------------------|
| CONCENTRATION | Yes / No / Not sure | Yes / No / Not sure |
| FALLING ASLEEP | Yes / No / Not sure | Yes / No / Not sure |
| STAYING ASLEEP | Yes / No / Not sure | Yes / No / Not sure |
| RESTAURANTS | Yes / No / Not sure | Yes / No / Not sure |
| SOCIAL EVENTS | Yes / No / Not sure | Yes / No / Not sure |
| CHURCH | Yes / No / Not sure | Yes / No / Not sure |
| SPORTS EVENTS | Yes / No / Not sure | Yes / No / Not sure |
| QUIET ACTIVITIES (e.g., reading) | Yes / No / Not sure | Yes / No / Not sure |
| CONCERTS | Yes / No / Not sure | Yes / No / Not sure |
| OTHER | Yes / No / Not sure | Yes / No / Not sure |

22. Do you feel depressed? If so, please explain why?

23. Are you currently seeing a mental health professional?

24. Did you have any depression or anxiety before the onset of tinnitus or hyperacusis? If so, when?

25. What medications are you currently taking, and what is each for (use an additional sheet if necessary) ?

26. How has tinnitus affected your home life?

27. How has tinnitus affected your social activities?

28. Do you have any legal action pending in relation to your tinnitus or hyperacusis, and/or are you planning legal action?

29. On the scale of 0 to 10 (0=none; 10= totally ruined), indicate the influence tinnitus and/or hyperacusis have on your life?

30. Rank (indicate by a number) how much these concern you (1=most and 3=least):

TINNITUS

HYPERACUSIS

HEARING LOSS

31. Please write below any other information related to your tinnitus or hyperacusis:



Dr. Emily E. McMahan, Au.D
 Doctor of Audiology

1005 E. Dimond Blvd Unit 3, Anchorage, AK 99515
 P: 907-522-4357 • F: 907-522-5631 • www.AllEarsAlaska.com

Tinnitus and Handicap Inventory (THI)

Instructions to patients: The purpose of the scale is to identify the problems your tinnitus may be causing you.
 Please circle YES, SOMETIMES or NO for each question below:

| Item | | Patient response | | |
|------|---|------------------|-----------|----|
| 1 | Because of your tinnitus is it difficult for you to concentrate? | Yes | Sometimes | No |
| 2 | Does the loudness of your tinnitus make it difficult for you to hear people? | Yes | Sometimes | No |
| 3 | Does your tinnitus make you angry? | Yes | Sometimes | No |
| 4 | Does your tinnitus make you feel confused? | Yes | Sometimes | No |
| 5 | Because of your tinnitus do you feel desperate? | Yes | Sometimes | No |
| 6 | Do you complain a great deal about your tinnitus? | Yes | Sometimes | No |
| 7 | Because of your tinnitus do you have trouble falling to sleep at night? | Yes | Sometimes | No |
| 8 | Do you feel as though you cannot escape your tinnitus? | Yes | Sometimes | No |
| 9 | Does your tinnitus interfere with your ability to enjoy social activities? | Yes | Sometimes | No |
| 10 | Because of your tinnitus do you feel frustrated? | Yes | Sometimes | No |
| 11 | Because of your tinnitus, do you feel that you have a terrible disease? | Yes | Sometimes | No |
| 12 | Does your tinnitus make it difficult for you to enjoy life? | Yes | Sometimes | No |
| 13 | Does your tinnitus interfere with your job or household responsibilities? | Yes | Sometimes | No |
| 14 | Because of your tinnitus do you find that you are often irritable? | Yes | Sometimes | No |
| 15 | Because of your tinnitus is it difficult for you to read? | Yes | Sometimes | No |
| 16 | Does your tinnitus make you upset? | Yes | Sometimes | No |
| 17 | Does tinnitus cause stress on your relationship with members of your family and friends? | Yes | Sometimes | No |
| 18 | Do you find it difficult to focus your attention away from your tinnitus and on other things? | Yes | Sometimes | No |
| 19 | Do you feel that you have no control over your tinnitus? | Yes | Sometimes | No |
| 20 | Because of your tinnitus do you often feel tired? | Yes | Sometimes | No |
| 21 | Because of your tinnitus do you feel depressed? | Yes | Sometimes | No |
| 22 | Does your tinnitus make you feel anxious? | Yes | Sometimes | No |
| 23 | Do you feel that you can no longer cope with your tinnitus? | Yes | Sometimes | No |
| 24 | Does your tinnitus get worse when you are under stress? | Yes | Sometimes | No |
| 25 | Does your tinnitus make your feel insecure? | Yes | Sometimes | No |

of "Yes" _____ x 4 # of "Sometimes" _____ x 2 =