

TH Inventory (Newman et al)

Instructions: The purpose of the questionnaire is to identify difficulties that you may experience because of your tinnitus. Please answer YES, SOMETIMES or NO, to each question. Please DO NOT SKIP any questions.

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



Initial Tinnitus Questionnaire

Patient Name:	Date:						
Reason for today's appointment:							
Allergies to any medications, plastics, etc. ?							
Current medications:							
Ear Health History							
Have you been exposed to loud sounds/noise?	☐Yes ☐No If yes, explain						
Have you ever had ear surgery? Yes No If yes, ear? Right Left type?							
Have you ever had any head/ear trauma? Yes No If yes, explain							
Have you ever taken medication that had a toxic	effect on your hearing? ☐Yes ☐No If yes, type?						
*Have you experienced any drainage from your e	ar(s) within the last 90 days? Yes No						
If yes, □Right □Left	□Both						
*Do you suffer from pain or discomfort in your ear	r(s)?						
If yes, □Right □Left	□Both						
Do you have temporomandibular joint (TMJ) diso	rder?						
If yes, □Right □Left	□Both						
Do you have a congenital or traumatic deformity of	of the ear?						
If yes, describe:							
Do you often have significant cerumen (earwax) a	accumulation in your ear canal?						
□Right □Left	□Both □Neither						
*Do you suffer from acute or chronic dizziness?	□Yes □No						
Please list all major surgeries (Past 10 years):							
Please list any serious illness (Past 10 years):							



Initial Tinnitus Questionnaire

Tinnitus

Tinnitus refers to any kind of sound in your headringing, hissing	g and so on. Think or	nly about your tinnitu	is in regard to
the following questions			
How does the tinnitus sound?		Constant? I	ntermittent?
In which ear is your tinnitus? ☐Right ☐ Left ☐Both	☐Head ☐Other		
How long ago did you notice the tinnitus? ☐ Recently ☐ 1-	3 years □3-10 ye	ears More than	10 years
Do you remember the onset of your tinnitus? ☐Yes ☐No			
Was it a sudden or progressive onset? ☐Sudden ☐Progre	essive		
Was it related to any other medical or environmental condition?	□Yes □No		
*Does your tinnitus pulse with your heartbeat?)		
*Is your tinnitus triggered by head or neck movement?	□No		
Is there any one in your family who has/had tinnitus?	□No		
Have you consulted any other professional or tried any treatment	for your tinnitus?	□Yes □No	
If yes, explain			
Does your tinnitus			
Make it difficult to fall asleep?	always	sometimes	never
Make it difficult to concentrate while reading?	always	sometimes	never
Make it difficult to relax in a quiet room?	always	sometimes	never
Make it difficult to focus your attention away from your tinnitus?	always	sometimes	never
Cause you to feel angry?	always	sometimes	never
Cause you to feel stressed?	always	sometimes	never
Cause you to feel sad?	always	sometimes	never
	Office U	Jse Only (2) (1) ((0) Total
Sound Tolerance			
Sound tolerance refers to how you react to sounds in your environ	nment. Think only ab	out your sound tole	rance in regard
to the following questions			
Do you use ear protection (earplugs or earmuffs) specifically for t	innitus?	□No	
Do you have a decreased tolerance to sound (are sounds bothers	some to you when the	ey seem normal to o	other people
around you)? Yes No	·		
Does sound in your environment			
Cause an increase in your tinnitus?	always	sometimes	never
Cause you to avoid going certain places?	always	sometimes	never
Cause you to feel irritated?	always	sometimes	never



Initial Tinnitus Questionnaire

Hearing

Hearing refers to your a	bility to	o detect	sounds	in your	enviro	nment oi	r you a	bility to ur	ndersi	tand the speec	h of other. Think
only about your hearing	in reg	ard to th	e follow	ing que	stions.						
When was your last hea	aring ex	xam?						By w	hom?		
What were the results?								_Recomme	ndatio	ons?	
Have you ever worn hearing aids?						□No					
*Have you experienced	a sudo	den heai	ring loss	s? []Yes	□No					
Does your hearing											
Limit or hamper your pe	rsonal	or socia	al life?					always		sometimes	never
Cause you to hear people but not understand what they are saying?								always		sometimes	never
What do you consider	is you	ır main	problei	m? He	earing	☐ Tir	nnitus	☐ Sou	und T	olerance	
If you answered "tinnit	us" as	your m	ain pro	blem	•						
What percent of the time	e are y	ou awar	e of it?								
How <i>strong</i> , or <i>loud</i> was ye can imagine." (Severity)	our tinn	itus, on a	average,	over the	last mo	onth? "0" \	would b	e "no tinnit	us" an	d "10" would be	"as loud as you
	1	2	3	4	5	6	7	8	9	10	
How much has tinnitus and annoying as you could ima				over the	last moi	nth? "0" w	ould be	e "not anno	ying a	t all" and "10" wo	ould be "as
	1	2	3	4	5	6	7	8	9	10	
How much did tinnitus imp	act you	r life, ove	er the las	st month	? "0" wo	uld be "no	ot at all	"; "10" woul	d be "	as much as you	could imagine."
	1	2	3	4	5	6	7	8	9	10	
Have you experienced a	any str	essful e	vents w	ithin the	last 12	2 months	i? 				
Additional Information:											