NELSON HEARING CLINICS

TINNITUS ASSESSMENT

Name _____ (First) _____ (Last) Today's date ____ / ____ / ____ (MM / DD / YYYY)

Reason for today's appointment: _____

_____

MEDICAL HISTORY (check any that apply)

☐Chemotherapy	☐Hearing loss in family	☐Prescription blood thinners
☐Stroke	☐Tinnitus in family	☐Radiation to head or neck
☐Diabetes	☐Memory concerns	☐Loud noise exposure
☐Parkinson's	☐Dizziness / imbalance	☐History of anxiety
☐Ear pain	☐Sinus infections	☐History of depression
☐Excessive earwax	☐Chronic ear infections	☐Significant stress in last 12 mo.

Other major health concerns? Describe. _____

_____

_____

TINNITUS (noise in the ear/head)

Describe the sound you hear: _____

_____

Would you describe the tinnitus as any of the following? (check any that apply)

☐Constant	☐Fluctuates in volume	☐Worsens with head movement
☐Intermittent	☐Began suddenly	☐Related to a medical condition
☐Pulsing	☐Steadily worsening	

Where do you hear the tinnitus? ☐Right ear ☐Left ear ☐Both ears ☐In head

When did you first become aware of the tinnitus? _____

When did the tinnitus first become disturbing? _____

What do you consider to have started the tinnitus? _____

_____

Provider Notes

400 N. State St.
Fairmont, MN 56031
P: (507) 235-5323
F: (507) 235-6126

119 E. 5th St.
Spencer, IA 51301
P: (712) 262-7774
F: (712) 262-6758

116 Central Ave. NE
Le Mars, IA 51031
P: (712) 546-4723
F: (712) 560-7421

712 4th Ave.
Sheldon, IA 51201
P: (712) 546-4723
F: (712) 560-7421

NELSON HEARING CLINICS

TINNITUS ASSESSMENT

TINNITUS (continued)

Provider Notes

How **loud** was the tinnitus on average over the last month?

Soft → 1 2 3 4 5 6 7 8 9 10 ← Loud

How **annoying** was the tinnitus on average over the last month?

Not very → 1 2 3 4 5 6 7 8 9 10 ← Very

How much of an **impact** did tinnitus have on your life over the last month?

Little impact → 1 2 3 4 5 6 7 8 9 10 ← Huge impact

How much of the time were you aware of the tinnitus, on average?

Never → 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% ← Always

Does the tinnitus...

Cause sleep problems?	☐Always	☐Sometimes	☐Never
Get worse if you haven't slept well?	☐Always	☐Sometimes	☐Never
Cause you to feel angry or sad?	☐Always	☐Sometimes	☐Never
Make you anxious or stressed?	☐Always	☐Sometimes	☐Never
Get worse if you are stressed?	☐Always	☐Sometimes	☐Never
Get worse if you drink too much caffeine?	☐Always	☐Sometimes	☐Never
Get worse if you eat too much sodium?	☐Always	☐Sometimes	☐Never
Make it hard to concentrate / relax?	☐Always	☐Sometimes	☐Never

What treatments have you tried for tinnitus?

_____

_____

Anything else you want us to know about the tinnitus and how it affects you?

_____

SOUND TOLERANCE (how you react to sounds in your environment)

Are sounds bothersome to you when they seem normal to others? ☐Yes ☐No

Do you ever use hearing protection specifically for tinnitus? ☐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

400 N. State St.
Fairmont, MN 56031
P: (507) 235-5323
F: (507) 235-6126

119 E. 5th St.
Spencer, IA 51301
P: (712) 262-7774
F: (712) 262-6758

116 Central Ave. NE
Le Mars, IA 51031
P: (712) 546-4723
F: (712) 560-7421

712 4th Ave.
Sheldon, IA 51201
P: (712) 546-4723
F: (712) 560-7421

NELSON HEARING CLINICS

TINNITUS ASSESSMENT

HEARING

Provider Notes

Does the tinnitus interfere with your ability to hear? ☐ Yes ☐ No

Do you feel you have a hearing loss . . ? ☐ Yes ☐ No

If yes, is one ear worse . . . . . ? ☐ Right ☐ Left

Did the hearing loss occur . . . . . ? ☐ Gradually ☐ Suddenly

When did you first notice the loss? _____

Have you ever had your hearing tested? ☐ Yes ☐ No

If yes, when and where? _____

How would *you* rate your hearing?

Worst → 1 2 3 4 5 6 7 8 9 10 ← Best

How would *your family* rate your hearing?

Worst → 1 2 3 4 5 6 7 8 9 10 ← Best

How important is it for you to hear better?

Not important → 1 2 3 4 5 6 8 9 10 ← Very important

Do you notice difficulties hearing or understanding with any of the following?

☐ Watching TV	☐ Car	☐ Small groups
☐ Noisy places	☐ Cell phone	☐ Meetings / work
☐ Restaurants	☐ Home phone	☐ Worship services
☐ Soft spoken people	☐ Children	☐ Family gatherings

Do these difficulties cause any of the following? (check any that apply)

☐ Tension with loved ones	☐ Avoid going certain places
☐ Disagreements over TV volume	☐ Frustration / embarrassment
☐ "Zone-out" of conversations	☐ No long enjoy music
☐ Feel left out of conversations	

HEARING AID HISTORY (skip section if you have never worn aid(s)

When did you first starting using hearing aid(s)? _____

For which ear(s) do you use hearing aid(s)? ☐ Right only ☐ Left only ☐ Both

How often do you currently wear aid(s)? ☐ Full-time ☐ Part-time ☐ Never

When were the hearing aid(s) fit? _____

At what clinic where they fit? _____

Describe any concerns about current aid(s):

_____

400 N. State St.
Fairmont, MN 56031
P: (507) 235-5323
F: (507) 235-6126

119 E. 5th St.
Spencer, IA 51301
P: (712) 262-7774
F: (712) 262-6758

116 Central Ave. NE
Le Mars, IA 51031
P: (712) 546-4723
F: (712) 560-7421

712 4th Ave.
Sheldon, IA 51201
P: (712) 546-4723
F: (712) 560-7421

NELSON HEARING CLINICS

TINNITUS QUESTIONNAIRE (THI)

INSTRUCTIONS: The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your tinnitus. Please answer every question. Please do not skip any questions.

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?	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 your social activities (such as going out to dinner, to the movies)?	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. Do you feel that your tinnitus problem has placed stress on your relationships 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 you feel insecure?	Yes	Sometimes	No

Yes: _____ Total THI Score: _____

Smt: _____ Category: S (0-16) Mld (18-36) Md (38-56) Sv (58-76) C (78-100)

No: _____