2014 AAI/TTC Tinnitus Profile Worksheet

Name:_____ Referred by:_____ Date:_____

Tinnitus History:

When did you **first notice** your tinnitus?_____

Under what circumstances or life issues?_____

_____

Has it changed in severity or pitch?_____ Was the **onset**: gradual sudden

Describe your tinnitus: Right ear Left ear Both ears Fluctuating Constant

Who have you seen about your tinnitus and what did they recommend?_____

_____

When is the tinnitus **most bothersome**?_____

When is the tinnitus **least bothersome**?_____

Is there anything that you can do to make your tinnitus better or worse?_____ If yes, explain.

_____

How has tinnitus affected your home and social life?_____

_____

How much does your tinnitus affect you emotionally? Give specific examples:_____

_____

_____

Hearing History:

Do you have a known hearing loss? _____ If so, when was your last evaluation and what degree of loss do you have?_____

Circle the options below that apply to your **current hearing ability**. I have difficulty:

hearing the TV hearing in noise understanding speech hearing soft voices no problems

Describe any **loud noise** you have been exposed to since childhood, including but not limited to guns, music, jobs or hobbies:_____

_____

Are you **hypersensitive** to loud sounds (more so than others) ?_____

Rank your auditory problems from most troublesome (1) to least troublesome (4) or (N/A):

Hearing loss_____ Tinnitus_____ Sound sensitivity_____ Dizziness _____

Do you have: frequent headaches neck/shoulder pain back pain teeth/jaw grinding or pain

Explain: _____

Have you had any **head trauma** or concussion in you life?_____

Is there a **family history** of: tinnitus hearing loss migraines dizziness

Is your intake of any of the following more than average? How much or how many per day?

Sugar_____ Salt/MSG:_____ Cola:_____ Tobacco:_____ Alcohol:_____

How many hours of **sleep** do you get per night on average?_____ Is it restful?_____

On a scale from 1 to 10 (10 being the worst) and if 5/10 is the average stress level for most people,

What would you rate your current **stress level**? ____/10. What do you contribute this to?

_____

_____

Are there other issues that may be contributory to your symptoms that may help us to help you?

_____

_____

_____

Doctor Notes:_____

_____

_____