

# EAR, NOSE AND THROAT ASSOCIATES OF CHESTER COUNTY

## Tinnitus Assessment

### History Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Chart Number: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

### Description of Tinnitus (check all that apply):

<input type="checkbox"/> High tone (ringing)	<input type="checkbox"/> Low Tone (humming)
<input type="checkbox"/> Rushing or 'Wind' sound	<input type="checkbox"/> Roaring
<input type="checkbox"/> Pulsing	<input type="checkbox"/> Clicking
<input type="checkbox"/> Popping	<input type="checkbox"/> Other: _____

### Onset of Tinnitus – When did symptoms begin?

<input type="checkbox"/> Date: _____	<input type="checkbox"/> A few days ago
<input type="checkbox"/> About a week ago	<input type="checkbox"/> About a month ago
<input type="checkbox"/> Several months ago	<input type="checkbox"/> About a year ago
<input type="checkbox"/> Several years ago	<input type="checkbox"/> Not sure

### Timing of Tinnitus – When is the tinnitus bothersome? (check all that apply)

<input type="checkbox"/> All the time	<input type="checkbox"/> Only at night
<input type="checkbox"/> Daily	<input type="checkbox"/> Only in morning
<input type="checkbox"/> Seasonally: _____	<input type="checkbox"/> Certain times weekly
<input type="checkbox"/> Certain conditions only (describe): _____	

### Additional Medical Conditions (check all that apply):

<input type="checkbox"/> Hearing Loss: ( <input type="checkbox"/> right <input type="checkbox"/> left)	<input type="checkbox"/> Sensitivity to certain sounds
<input type="checkbox"/> Headache	<input type="checkbox"/> Diagnosed Migraine
<input type="checkbox"/> Head trauma	<input type="checkbox"/> Depression
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Low blood pressure
<input type="checkbox"/> Vertigo	<input type="checkbox"/> Imbalance

How bothersome is the tinnitus?  Extremely  Very  Somewhat  
 Little  None

### Recent Medicine Changes (within past six months):

Medication	Date Changed
<input type="checkbox"/> added <input type="checkbox"/> dropped	
<input type="checkbox"/> added <input type="checkbox"/> dropped	
<input type="checkbox"/> added <input type="checkbox"/> dropped	
<input type="checkbox"/> added <input type="checkbox"/> dropped	
<input type="checkbox"/> added <input type="checkbox"/> dropped	