WIDEX®
HIGH DEFINITION HEARING

TINNITUS HANDICAP INVENTORY (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.

Name:______________________________ Date:______________

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

For Clinician Use Only **Total Score Per Column** [ ] [ ] [ ]

Total THI Score: (number of "yes" responses x 4) + (number of "sometimes" responses x 2) = **Total Score** [ ]

0 – 16	Slight (Only heard in quiet environments)	GRADE 1
18 – 36	Mild (Easily masked by environmental sounds and easily forgotten with activities)	GRADE 2
38 – 56	Moderate (Noticed in presence of background noise, although daily activities can still be performed)	GRADE 3
58 – 76	Severe (Almost always heard, leads to disturbed sleep patterns and can interfere with daily activities)	GRADE 4
78 – 100	Catastrophic (Always heard, disturbed sleep patterns, difficulty with any activities)	GRADE 5

REFERENCES

Newman, C. W., Jacobson, G. P., & Spitzer, J. B. (1996). Development of the Tinnitus Handicap Inventory. *Arch Otolaryngol Head Neck Surg*, 122, 143-148.

McCombe, A., Bagueley, D., Coles, R., McKenna, L., McKinney, C. & Windle-Taylor, P. (2001). Guidelines for the grading of tinnitus severity: The results of a working group commissioned by the British Association of Otolaryngologists, Head and Neck Surgeons, 1999. *Clin Otolaryngol*, 26, 388-393.

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PATIENT INTAKE FORM

EAR AND HEARING-RELATED PROBLEMS

Clinic ID:

Name:

Date:

To help us in planning of your visit please answer questions listed below to the best of your abilities and provide comments, if needed. Use back page if you need more space.

For the Clinic Use

1. Do you have **TINNITUS** (ringing in the ears) ❑ Yes ❑ No
   Does it bothers you? ❑ Yes ❑ Sometimes ❑ No
   What is the biggest problem with your tinnitus?
   ____
   ____

2. Is your tolerance to **LOUDER** sounds the same as people around you? ❑ Yes ❑ No
   If **No** please list sounds which bother you ____________________
   ____
   and how these sound affect you ____________________
   ____

3. Is your tolerance to **SPECIFIC** sounds the same as people around you? ❑ Yes ❑ No
   If **No** please list sounds and situations / people you associated with these bothersome sounds ____________________
   ____
   ____
   and how these sounds affect you ____________________
   ____

4. Please list / describe any additional ear-related problems, bothersome sensations which you experience ____________________
   ____
   ____

5. Do you have family (please state relationship) history of
   Hearing loss ____________________
   Tinnitus ____________________
   Decreased Sound Tolerance ____________________
   Other ear/hearing related problems ____________________

6. Have you had your hearing tested before? ❑ Yes ❑ No (If Yes, please bring / send the results)

For the Clinic Use

7. Do you feel you have difficulty hearing (hearing loss)? ❑ Yes ❑ No
   If **Yes** what ear(s) are affected ❑ Both ears, ❑ Right ear, ❑ Left ear
   Additional comments (e.g., sudden/gradual, if known, the reason, largest difficulty)
   ____
   Do you wear hearing aids? ❑ Yes ❑ No Model ______________

8. Do you have or you ever experienced the following ear problems?

Fullness	❑ Yes ❑ No	Wax blockage	❑ Yes ❑ No
Pain	❑ Yes ❑ No	Ear infections	❑ Yes ❑ No
Drainage	❑ Yes ❑ No		

9. Have you ever experienced
   Vertigo (room spinning) ❑ Yes ❑ No
   Dizziness (lightheaded) ❑ Yes ❑ No
   Being off balance (unsteadiness, falling or feeling as going to fall) ❑ Yes ❑ No

10. Have you ever had (and when), any trauma / concussion to your head / neck (including but not only noise trauma) ❑ Yes ❑ No ______________
    ____

11. Have you ever had surgical / medical intervention to your ears (even tubes as a child) ❑ Yes ❑ No ______________
    ____

12. Have you been exposed to noises listed below, how often, type of ear protection used (foam, earmuffs, custom earplugs). Please elaborate
    Occupational (military, factory, construction) ______________
    ____
    Firing guns (type of guns) ______________
    ____
    Recreational (e.g., loud concerts) ______________
    ____
    Power tools, lawnmowers ______________
    ____
    Noise in close proximity (e.g., airbags explosion, close by firecrackers) ________
    ____
    Additional information ______________
    ____
    ____

MEDICATIONS

1. Please list names of ALL medications and supplements (including herbal) which you are taking

Medication	Dose	How long	Reason
Lisinopril	5 mg / 2 times a day	2 years	high blood pressure

2. Were you ever treated with any medications listed below
   - antibiotics intravenously ❑ Yes ❑ No (provide name of antibiotic)
   - anticancer drugs ❑ Yes ❑ No (provide the name)
   - nonsteroidal anti-inflammatory drugs (large doses, for long time, e.g., ibuprofen) ❑ Yes ❑ No
   - quinine ❑ Yes ❑ No
   - loop diuretics (e.g., furosemide) ❑ Yes ❑ No
3. Do you drink alcohol ❑ Yes ❑ Occasionally ❑ No
4. Do you use recreational drugs ❑ Yes ❑ Occasionally ❑ No
5. Do you use tobacco products ❑ Yes ❑ Occasionally ❑ No

For the Clinic Use

OTHER MEDICAL PROBLEMS

Do you have the history of being diagnosed with any problems listed below

Diabetes type 1 or 2	❑ Yes ❑ No	Autoimmune disease	❑ Yes ❑ No
Depression	❑ Yes ❑ No	Lyme disease	❑ Yes ❑ No
Anxiety	❑ Yes ❑ No	Mumps	❑ Yes ❑ No
Dementia or cognitive decline	❑ Yes ❑ No	Measles	❑ Yes ❑ No
Cardiovascular disease	❑ Yes ❑ No	Scarlet fever	❑ Yes ❑ No
High blood pressure	❑ Yes ❑ No	Cancer	❑ Yes ❑ No
Kidney disease	❑ Yes ❑ No		

Any other significant medical problem not listed above

______________________________ Date ________________

Signature (patient / parent / caregiver)