BUTLER
COUNTY HEALTH
Audiology Services

Tinnitus Assessment

Name: ______________________ **Date:** __________

Address: ______________________

Phone: ______________________ **Birthday:** __________

INSTRUCTIONS: This questionnaire has 20 questions. Please circle the answer that most closely applys to you.

1	Does your tinnitus make it difficult for you to hear others?	Yes	Sometimes	Often
2	My tinnitus masks some speech sounds.	Yes	Sometimes	Often
3	Does your tinnitus make you feel confused?	Yes	Sometimes	Often
4	Does your tinnitus make you angry?	Yes	Sometimes	Often
5	I have difficulty falling asleep at night because of my tinnitus.	Yes	Sometimes	Often
6	Do you complain a great deal about your tinnitus?	Yes	Sometimes	Often
7	My tinnitus makes it difficult for me to concentrate on some tasks.	Yes	Sometimes	Often
8	I am depressed because of my tinnitus.	Yes	Sometimes	Often
9	Does your tinnitus interfere with your job or other responsibilities?	Yes	Sometimes	Often
10	I am anxious because of my tinnitus.	Yes	Sometimes	Often
11	Because of your tinnitus, do you find it difficult to read?	Yes	Sometimes	Often
12	Does your tinnitus make it difficult for you to enjoy life?	Yes	Sometimes	Often
13	Does your tinnnitus place stress on your relationships with others?	Yes	Sometimes	Often
14	My tinnitus interferes with my understanding of speech.	Yes	Sometimes	Often
15	Do you avoid social activities because of your tinnitus?	Yes	Sometimes	Often
16	I am tired during the day because my tinnitus has disrupted my sleep.	Yes	Sometimes	Often
17	Does your tinnitus get worse when you are under stress?	Yes	Sometimes	Often
18	I lie awake at night because of my tinnitus.	Yes	Sometimes	Often
19	Do you feel insecure because of your tinnitus?	Yes	Sometimes	Often
20	Do you find your tinnitus makes you irratable?	Yes	Sometimes	Often
	Totals			