TINNITUS PATIENT SCREENING TOOL

Please circle the response that most accurately reflects your feelings about your tinnitus.

(1 = Not often, 5 = Very often)

1. How often do you feel frustrated by your tinnitus? 1 2 3 4 5
2. How often does your tinnitus make it difficult for you to concentrate or focus? 1 2 3 4 5
3. How often does your tinnitus negatively affect your sleeping habits? 1 2 3 4 5
4. How often does your tinnitus negatively impact your life? 1 2 3 4 5
5. How often does your tinnitus affect your family/social relationships? 1 2 3 4 5

Total: ________*

*If this value is 10 or higher, we recommend an immediate consultation. Case by case factors should also be considered.

If someone could help you understand your tinnitus better, would you be interested? Yes No

Note: This tool is designed to be used as a screening tool only. It is not intended for diagnostic purposes, and should not take the place of formal questionnaires and/or informative counseling administered by a hearing care professional.