RECENT-ONSET TINNITUS PROTOCOL

(Translated from Greek)

DATE:

Name: Sex:

Address: Phone:

Age: Occupation:

Hearing loss – Vertigo – Feeling of ear pressure:

Otological history:

Neurological symptoms:

Psychological symptoms (anxiety, depression, insomnia):

Systemic diseases:

Medications:

Noise exposure:

TINNITUS

Months since tinnitus onset: ☐

Laterality: Right ☐ Left ☐ Bilateral ☐ Unspecified ☐

Continuity: Continuous ☐ Intermittent ☐

Tinnitus stability: Stable ☐ Changing loudness ☐

Tinnitus description (whistling, blowing, ringing, etc.):

Specific tinnitus features (pulsatile, synchronous with breathing, etc.):

Severity: Mild ☐ Moderate ☐ Severe ☐

Other remarks:

DATE OF FIRST TESTING SESSION: _____

Puretone Audiogram (air and bone conduction)

	0.25 kHz	0.5 kHz	1 kHz	2 kHz	4 kHz	6 kHz	8 kHz	10 kHz	12 kHz	15 kHz	18 kHz
(R) bone conduction											
(L) bone conduction											
(R) air conduction											
(L) air conduction											

Tympanometry

SPECIFIC MEASURES OF TINNITUS PERCEPTION

1. Tinnitus pitch test (tone or NBN)

Dominating frequency: _____ Hz

2. Tinnitus loudness (tone or NBN)

Dominating frequency: ____ dB

1000 Hz: ____ dB

3. Minimum masking level (MML) with white noise

Masking level:

Complete masking ☐ Partial masking ☐ Absence of masking ☐

4. Residual inhibition (broad band noise)

Stimulus: MML + 10 dB for 60 sec

Complete inhibition ☐ Partial inhibition ☐ Absence of inhibition ☐

IMAGING STUDIES

MRI:

MRA:

CT:

TINNITUS HANDICAP INVENTORY (THI) – First Testing Session

Name:

Date:

Instructions: The purpose of this questionnaire is to identify, quantify, and evaluate the difficulties that you may be experiencing because of tinnitus. Please encircle one of "Yes", "Sometimes" or "No" and do not skip any questions.

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

Evaluation: Yes (4) Sometimes (2) No (0)
THI Score:

MINI TINNITUS QUESTIONNAIRE (mini-TQ) – First Testing Session

Name:

Date:

Instructions: Please encircle one of “True”, “Partly true” or “Not true” and do not skip any questions.

1. I am aware of the noises from the moment I get up to the moment I sleep	True	Partly true	Not true
2. Because of the noises I worry that there is something seriously wrong with my body	True	Partly true	Not true
3. If the noises continue my life will not be worth living	True	Partly true	Not true
4. I am more irritable with my family and friends because of the noises	True	Partly true	Not true
5. I worry that the noises might damage my physical health	True	Partly true	Not true
6. I find it harder to relax because of the noises	True	Partly true	Not true
7. My noises are often so bad that I cannot ignore them	True	Partly true	Not true
8. It takes me longer to get to sleep because of the noises	True	Partly true	Not true
9. I am more liable to feel low because of the noises	True	Partly true	Not true
10. I often think about whether the noises will ever go away	True	Partly true	Not true
11. I am a victim of my noises	True	Partly true	Not true
12. The noises have affected my concentration	True	Partly true	Not true

Evaluation: True (2), Partly true (1), Not true (0)
Mini-TQ score:

PATIENT'S GLOBAL IMPRESSION OF CHANGE (PGIC) – First Testing Session

Name:

Date:

Instructions: What is your impression of change of your tinnitus during the 3-month treatment? Please check one of the following 5 answers.

0. The same or worsened: ☐
1. Slight improvement: ☐
2. Moderate improvement: ☐
3. Significant improvement: ☐
4. Remission: ☐

DATE OF SECOND TESTING SESSION: _____

Name:

Puretone Audiogram (air and bone conduction)

	0.25 kHz	0.5 kHz	1 kHz	2 kHz	4 kHz	6 kHz	8 kHz	10 kHz	12 kHz	15 kHz	18 kHz
(R) bone conduction											
(L) bone conduction											
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Tympanometry

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Dominating frequency: ____ dB

1000 Hz: ____ dB

3. Minimum masking level (MML) with white noise

Masking level:

Complete masking ☐ Partial masking ☐ Absence of masking ☐

4. Residual inhibition (broad band noise)

Stimulus: MML + 10 dB for 60 sec

Complete inhibition ☐ Partial inhibition ☐ Absence of inhibition ☐

Please notice any change of tinnitus during the 3-month treatment:

REMARKS:

TINNITUS HANDICAP INVENTORY (THI) – Second Testing Session

Name:

Date:

Instructions: The purpose of this questionnaire is to identify, quantify, and evaluate the difficulties that you may be experiencing because of tinnitus. Please encircle one of "Yes", "Sometimes" or "No" and do not skip any questions.

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6. Do you complain a great deal about your tinnitus	Yes	Sometimes	No
7. Because of your tinnitus, do you have trouble falling to sleep at night?	Yes	Sometimes	No
8. Do you feel as though you cannot escape your tinnitus?	Yes	Sometimes	No
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23. Do you feel that you can no longer cope with your tinnitus?	Yes	Sometimes	No
24. Does your tinnitus get worse when you are under stress?	Yes	Sometimes	No
25. Does your tinnitus make you feel insecure?	Yes	Sometimes	No

Evaluation: Yes (4), Sometimes (2), No (0)
THI Score:

MINI TINNITUS QUESTIONNAIRE (mini-TQ) – Second Testing Session

Name:

Date:

Instructions: Please encircle one of "True", "Partly true" or "Not true" and do not skip any questions.

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5. I worry that the noises might damage my physical health	True	Partly true	Not true
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7. My noises are often so bad that I cannot ignore them	True	Partly true	Not true
8. It takes me longer to get to sleep because of the noises	True	Partly true	Not true
9. I am more liable to feel low because of the noises	True	Partly true	Not true
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11. I am a victim of my noises	True	Partly true	Not true
12. The noises have affected my concentration	True	Partly true	Not true

Evaluation: True (2), Partly true (1), Not true (0)
Mini-TQ score:

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Name:

Date:

Instructions: What is your impression of change of tinnitus during the 3-month treatment? Please check one of the following 5 answers.

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2. Moderate improvement: ☐
3. Significant improvement: ☐
4. Remission: ☐