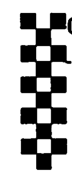

Veterans Affairs Canada Anciens Combattants Canada

MEDICAL QUESTIONNAIRE FOR TINNITUS

NAME:	DOB:	FILE #:

TINNITUS

Does the client report tinnitus? ☐ Yes ☐ No

If yes, please describe the tinnitus:

Please indicate the occurrence of tinnitus?

- ☐ occasional tinnitus, present less than once a week affecting one or both ears.
- ☐ occasional tinnitus, present at least once a week affecting one or both ears.
- ☐ intermittent tinnitus, present daily, but not all day long, affecting one or both ears.
- ☐ continuous tinnitus, present all day and all night, everyday, affecting one or both ears, but does not require use of prescribed masking device and /or other prescribed modalities. May require non-prescribed devices such as radio, etc.
- ☐ continuous tinnitus, present all day and all night, everyday, affecting one or both ears, and requiring the ongoing use of prescribed masking device and/or prescribed modalities.

Please check all those interventions that the client has tried to assist in coping with his/her tinnitus:

- ☐ radio/television/music/ background sounds
- ☐ medication
- ☐ self-hypnosis or hypnosis by a professional
- ☐ physical activity
- ☐ decreasing salt intake
- ☐ decreasing caffeine intake
- ☐ stop smoking
- ☐ support/sympathy/understanding from a spouse/ friend/other
- ☐ use of hearing aid
- ☐ use of tinnitus masker
- ☐ relaxation therapy
- ☐ biofeedback
- ☐ acupuncture
- ☐ distraction activity
- ☐ counselling (please specify)
- ☐ other (please specify)________

Has the client attended a "Tinnitus Evaluation Centre? ☐ Yes ☐ No

If yes, please include a copy of the consultant's report.

7. ADDITIONAL COMMENTS

8. OTHER CONDITIONS

Are there any other medical conditions which may be compounding the impairment caused by the pensioned condition? ☐ Yes ☐ No

If yes, please elaborate:

CLINICAL AUDIOLOGIST'S NAME AND SIGNATURE DATE