The HearingCenter℠
Medical Center Clinic

Tinnitus Handicap Inventory (THI)

Instructions: The purposes of the THI is to define the subjective severity of your tinnitus and how it's affecting your life. Please circle a response for every question. Do not skip 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 asleep 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, going 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/or 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

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Total Score Per Column _____ _____ _____

Total THI Score: (number of "yes" responses x4) + (number of "sometimes" responses x2) = **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

For Amplification/Cochlear Implant Wearers:

Do you experience any of the following with your current device(s)? Please check all that apply:

- ☐ Some sounds are too loud
- ☐ Sounds are too soft
- ☐ Pain: _____
- ☐ Sounds are tinny or metallic
- ☐ Trouble understanding in quiet
- ☐ Wind noise
- ☐ Trouble using the telephone
- ☐ Feedback or whistling
- ☐ Trouble understanding in noise
- ☐ Do not like appearance of device
- ☐ Do not like sound of own voice
- ☐ Cannot tell direction of sound

Medical History

Mark the following issues to the best of your ability as it relates to your hearing health.

- ☐ Developmental Disorders/Delays: Please explain: _____
- ☐ Dizziness or Unsteadiness Accompanied by ☐ Vomiting ☐ Nausea ☐ Ear Noise ☐ Falling
  Is the sensation Constant Episodic (comes and goes)
- ☐ Ear Deformity ☐ Right ear ☐ Left ear ☐ Both ears
- ☐ Ear Drainage ☐ Right ear ☐ Left ear ☐ Both ears
- ☐ Ear Pain ☐ Right ear ☐ Left ear ☐ Both ears
- ☐ Family History of Hearing Loss Who? _____
- ☐ History of Ear Infections ☐ Right ear ☐ Left ear ☐ Both ears If so, when? _____
- ☐ History of Ear Wax Buildup Last removed by doctor: _____
- ☐ Occurrences of Loud Noises What/When? _____
- ☐ Previous Ear Surgery ☐ Right ear ☐ Left ear ☐ Both ears If so, when? _____
- ☐ Tinnitus/Ringing/Noise in Ears ☐ Right ear ☐ Left ear ☐ Both ears Frequency? _____
  When did it begin? _____ Describe: _____
- ☐ Punctured Ear Drum ☐ Right ear ☐ Left ear ☐ Both ears Surgery? _____
- ☐ Other: _____

List any other illnesses, surgeries, injuries, or hospitalizations of the head and neck since birth and date(s) of occurrence:

_____

_____

Please indicate any of the following medical conditions to the best of your ability:

- ☐ AIDS/HIV
- ☐ Arthritis
- ☐ Blood Disorders
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Chemotherapy
- ☐ Regular MRI
- ☐ Encephalitis
- ☐ Fatigue
- ☐ Genetic Disorders
- ☐ Headaches
- ☐ Head Injury
- ☐ Heart Problems
- ☐ Contact Dermatitis
- ☐ High Blood Pressure
- ☐ High Fevers
- ☐ Measles
- ☐ Meningitis
- ☐ Mumps
- ☐ Stroke
- ☐ Exostosis
- ☐ Tonsillitis
- ☐ Typhoid
- ☐ Vascular Problems
- ☐ Auto Immune Disorder
- ☐ Radiation Therapy
- ☐ Bleeding Disorder
- ☐ Implantable Device
- ☐ Diabetes Insulin-dependent or uncontrolled? _____
- ☐ Other: _____

List all current medications (over the counter, prescriptions, or recreational):

_____

_____

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For audiologist use only: