



Tinnitus Handicap Inventory

Name _____ M F Date _____ DOB _____

Medical Record Number _____

The purpose of this scale is to identify the problems your tinnitus may be causing you.

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

Score (4 for each yes, 2 for each sometimes) _____ + _____ = _____

Grade (<18=1, 18-36=2, 38-56=3, 58-76=4, >76=5) _____