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**European School for Interdisciplinary Tinnitus Research – Screening Questionnaire (ESIT-SQ)**

This questionnaire has two parts.

In part A, we ask for some general personal characteristics such as age, height, life-style questions and conditions that might concern you. Everyone can complete part A, even if you've never had tinnitus. The estimated time to complete this part is 5 minutes.

If you have experienced tinnitus during the past year, you will be asked some more tinnitus-related questions in part B. The estimated time to complete part B is between 5 and 10 minutes, depending on how you answer.

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| **PART A. INDIVIDUAL CHARACTERISTICS** |
| For the following questions, please give the answer that best describes you and your experiences. For some questions you can choose more than one option. |
| A1  | Age (years) |
|  | \_ \_ |
| A2 | At birth were you described as: |
|  | ☐ Male ☐ Female ☐ Intersex ☐ Prefer not to say |
| A3 | What is your height? |
|  | \_ \_ \_ cm OR \_ feet \_ inches |
| A4 | What is your weight? |
|  | \_ \_ \_ kg OR \_ st \_ lbs |
| A5 | What is the highest education level you have achieved? |
|  | ☐ No school ☐ Primary (elementary school) ☐ Lower secondary (middle school) ☐ Upper secondary (high school) ☐ University or higher degree |
| A6 | What is the average number of alcoholic drinks that you consume per week?  |
|  | One drink equals 125 ml of wine, 330 ml of beer or 40 ml of spirits |
|  | \_ \_ |
| A7 | Which of the following options best describes your smoking status? |
|  | ☐ Never smoker ☐ Current Smoker ☐ Ex-smoker |
| A8 | How many first degree relatives (parents, children, siblings) do you know to have tinnitus or hearing loss?  |
|  | Please write a number next to each family member. |
|  | \_\_ Father \_\_ Mother \_\_ Brothers \_\_ Sisters \_\_ Sons \_\_ Daughters  |
| A9 | Do you suffer from vertigo (sensation of spinning or tilting)? |
|  | ☐ Never ☐ Yes, less than one episode per year☐ Yes, at least one episode per year  |
| A10 | Have you been diagnosed with any other ear condition?  |
|  | You can choose more than one option. |
|  | ☐ Acoustic trauma (caused by loud sounds) ☐ Ear barotrauma (caused by acute change in ambient pressure) ☐ Presbycusis (aging of ears) ☐ Sudden hearing loss☐ Other hearing loss ☐ Meniere's disease ☐ Acoustic neuroma (auditory nerve tumour) ☐ Acute otitis (ear inflammation) ☐ Serous otitis or Eustachian tube dysfunction ☐ Chronic otitis (e.g. tympanic perforation, cholesteatoma) ☐ Otosclerosis (reduced ossicles mobility) ☐ Other ear disorders. Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ No |
| A11 | Have you ever undergone any of the following procedures?  |
|  | You can choose more than one option. |
|  | ☐ Ear surgery ☐ Dental surgery ☐ Neurosurgery ☐ Lumbar puncture ☐ Chemotherapy ☐ Head and neck radiotherapy ☐ Electroconvulsive therapy ☐ Other procedure. Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_☐ None of these |
| A12 | Over the last week, have external sounds been a problem, being too loud or uncomfortable for you when they seemed normal to others around you? Note: external sounds refer to any sounds other than tinnitus, e.g. environmental sounds, speech, music. |
|  | ☐ No, not a problem ☐ Yes, a small problem ☐ Yes, a moderate problem ☐ Yes, a big problem ☐ Yes, a very big problem |
| A13 | Do you currently have any other difficulty with your hearing, such as listening to speech in a noisy situation? |
|  | ☐ Yes, cannot hear at all ☐ Yes, severe difficulty ☐ Yes, moderate difficulty ☐ Yes, slight difficulty ☐ No difficulty ☐ Do not know |
| A14 | Do you use any of the following devices?  |
|  | You can choose more than one option. |
|  | ☐ Hearing aid ☐ Cochlear implant ☐ Sound generator ☐ Combination device (hearing aid and sound generator in the same device) ☐ None |
| A15 | Do you suffer from any of the following pain syndromes?  |
|  | You can choose more than one option. |
|  | ☐ Headache ☐ Neck pain ☐ Ear pain ☐ Temporomandibular joint pain ☐ Pain in the face ☐ Other. Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_☐ No  |
| A16 | Do you have any of the following conditions that have been diagnosed by a clinician?  |
|  | You can choose more than one option. |
|  | **Oral:** ☐ Temporomandibular joint disorder ☐ Dental problems **Neurological:** ☐ Meningitis ☐ Multiple sclerosis ☐ Epilepsy ☐ Stroke ☐ Other cerebrovascular disease ☐ Dementia ☐ Other neurologic disease **Psychiatric or psychological:** ☐ Anxiety ☐ Depression ☐ Emotional trauma ☐ Excessive stress **Sleep disorders:** ☐ Difficulty falling asleep ☐ Difficulty staying asleep **Cardiovascular:** ☐ Low blood pressure☐ High blood pressure ☐ Myocardial infraction (heart attack) **Endocrine and metabolic:** ☐ Thyroid disorder ☐ Diabetes ☐ Hyperinsulinemia ☐ Increased cholesterol **Rheumatological and immune mediated:** ☐ Rheumatoid arthritis ☐ Systemic lupus erythematosus **Otorhinolaryngological:** ☐ Chronic sinusitis ☐ Nasal septum deviation **Infectious:** ☐ Syphilis ☐ HIV ☐ Lyme disease **Other:** ☐ Anaemia ☐ Instability or other balance disorders ☐ Acid/gastroesophageal reflux ☐ Globus hystericus ☐ Other. Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_☐ None  |
| A17 | Tinnitus refers to the perception of noise in your head or ears (such as ringing or buzzing) in the absence of any corresponding source of sound external to your head. Over the past year, have you had tinnitus in your head or in one or both ears that lasts for more than five minutes at a time? |
|  | ☐ Yes, most or all of time ☐ Yes, a lot of the time ☐ Yes, some of the time ☐ No, not in the past year ☐ No, never ☐ Do not know |
| Thank you for completing part A. If you answered "Yes" in question A17, please proceed to Part B. If you answered "No" or “Do not know” in question A17, that is the end of the questionnaire. Thank you for participating in this survey. |
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| **PART B. TINNITUS CHARACTERISTICS** |
| Thank you for completing Part A. For the following questions, please give the answer that best describes your tinnitus and its relationship to other conditions. For some questions you can choose more than one option.  |
| B1 | How often do you have tinnitus on average? |
|  | ☐ Daily or almost daily ☐ Almost weekly ☐ Almost monthly ☐ Every few months ☐ Yearly |
| B2 | What best describes your tinnitus during a day? |
|  | ☐ Constant: you can always or usually hear it in a quiet room ☐ Intermittent: "comes and goes", cannot always hear it in a quiet room  |
| B3 | How long ago did your tinnitus appear? |
|  | \_ \_ months \_ \_ years ☐ Do not know |
| B4 | Over the past year, how much does your tinnitus worry, annoy or upset you when it is at its worst? |
|  | ☐ Severely ☐ Moderately ☐ Slightly ☐ Not at all ☐ Do not knowIf you answered "Not at all" or “Do not know”, please go to question B6. |
| B5 | How long ago did your tinnitus start bothering you? |
|  | \_ \_ months \_ \_ years ☐ Do not know |
| B6 | Although, most patients have tinnitus of a single type, some may hear different sounds. Do you hear one or more different sounds? |
|  | ☐ One sound ☐ More than one different sound |
|  | In case you hear more than one different sound, please try to answer what best describes your most bothersome type of tinnitus in the following questions. |
| B7 | How was the start of your tinnitus? |
|  | ☐ Gradual ☐ Sudden ☐ Do not know |
| B8 | If you reported any conditions/procedures in questions A9, A10, A11, A12, A13, A15 or A16, please list them here and write next to them if they happened BEFORE, AFTER, or at about the SAME TIME as your tinnitus onset. |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| B9 | Was the initial onset of your tinnitus related to (you can choose more than one option):   |
|  | ☐ Exposure to loud sounds ☐ Change in hearing ☐ Exposure to change in ambient pressure (e.g. flight or diving) ☐ Flu, common cold or other infection ☐ Feeling of fullness or pressure in the ears ☐ Stress ☐ Head trauma ☐ Neck trauma (e.g. whiplash) ☐ Other. Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ☐ None |
| B10 | Were you taking any of the medicines listed below around the time of your tinnitus onset?  |
|  | You can choose more than one option. |
|  | ☐ Aspirin ☐ Pain killing medication. Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_☐ Oral steroids. Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_☐ Antibiotics. Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_☐ Antidepressants. Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_☐ Quinine (muscle cramps, malaria) ☐ Water tablets (diuretics). Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_☐ Other medicines. Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_☐ No☐ Do not know  |
| B11 | Do you think any of the conditions mentioned before or any other conditions are related to your tinnitus onset? |
|  | You can give up to 3 responses - please choose the most important. |
|  | ☐ No ☐ Yes. Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| B12 | Is the loudness of your tinnitus stable over time or does it fluctuate over a day? |
|  | ☐ Stable ☐ Sometimes fluctuating ☐ Always fluctuating ☐ Do not know |
| B13 | What does your tinnitus sound like?   |
|  | ☐ Tonal  ☐ Noise-like ☐ Music-like ☐ Crickets ☐ Other. Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| B14 | Please describe the pitch of your tinnitus: |
|  | ☐ High pitched ☐ Medium pitched ☐ Low pitched ☐ Do not know |
| B15 | Where do you perceive your tinnitus? |
|  | ☐ Right ear ☐ Left ear ☐ Both ears, worse in right ☐ Both ears, worse in left  ☐ Both ears, equally ☐ Inside the head  ☐ Other. Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_☐ Do not know |
| B16 | Is your tinnitus rhythmic? |
|  | ☐ No ☐ Yes, following heart beat (can be checked by feeling the pulse at the same time as listening to the tinnitus) ☐ Yes, following breathing ☐ Yes, following movements of the head, neck, jaw or muscles of the face ☐ Other. Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| B17 | Has a clinician ever heard your tinnitus? |
|  | ☐ Yes ☐ No |
| B18 | Is your tinnitus reduced by (you can choose more than one option): | B19 | Is your tinnitus increased by (you can choose more than one option): |
|  | ☐ Very quiet environment ☐ Low intensity sounds ☐ High intensity sounds ☐ Head movements ☐ Clenching the teeth or moving the jaw ☐ Pressing your head, neck, or area around the ear ☐ Taking a nap ☐ Good sleep quality ☐ Driving ☐ Being stressed or anxious ☐ Being relaxed ☐ Drinking alcohol ☐ Drinking coffee ☐ Medications ☐ Using hearing aids ☐ Other. Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_☐ None |  | ☐ Very quiet environment ☐ Low intensity sounds ☐ High intensity sounds ☐ Head movements ☐ Clenching the teeth or moving the jaw ☐ Pressing your head, neck, or area around the ear ☐ Taking a nap ☐ Poor sleep quality ☐ Driving ☐ Being stressed or anxious ☐ Being relaxed ☐ Drinking alcohol ☐ Drinking coffee ☐ Medications ☐ Using hearing aids ☐ Other. Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_☐ None |
| B20 | Over the past year, have you seen your family doctor, or seen a healthcare professional at a clinic or hospital about your tinnitus? |
|  | ☐ Yes, 5 or more visits ☐ Yes, from 2 to 4 visits ☐ Yes, just one visit ☐ Not at all ☐ Do not know |
| B21 | Are you currently receiving any of the following types of management for your tinnitus?  |
|  | You can choose more than one option. |
|  | ☐ Psychiatric management ☐ Psychological management ☐ Audiological management ☐ Physiotherapy ☐ Self-management (e.g. dietary supplements, support groups, relaxation) ☐ Other. Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_☐ No management |
| B22 | Do you think any of the conditions mentioned before, or any other conditions, are related to periods of increased tinnitus? |
|  | You can give up to 3 responses - please choose the most important. |
|  | ☐ No ☐ Yes. Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| Thank you for participating in this survey. |