Hearing Questionnaire

DILWORTH HEARING

PATIENT NAME: _____ D.O.B: _____

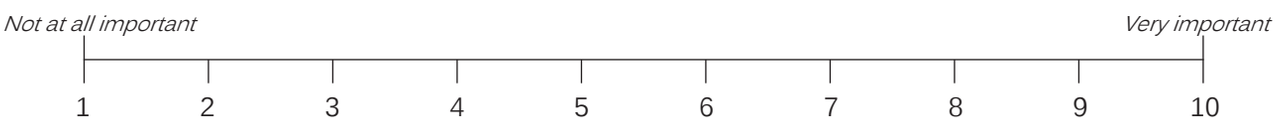
PH: _____ EMAIL: _____

ADDRESS: _____

Please answer the following questions so we can help you in the best way possible:

1. On a scale from 1 to 10, 1 being poor and 10 being excellent, how would you rate your hearing?

2. How important is it for you to improve your hearing right now?



Instructions: Select *No*, *Sometimes*, or *Yes* in response to each question. If you do not engage in a particular activity, respond according to the way you feel you would respond in that situation.

1. Does a hearing problem cause you to feel embarrassed when you meet new people?

☐ No ☐ Sometimes ☐ Yes

2. Does a hearing problem cause you to feel frustrated when talking to members of your family?

☐ No ☐ Sometimes ☐ Yes

3. Do you have difficulty hearing or understand co-workers, clients, or customers?

☐ No ☐ Sometimes ☐ Yes

4. Do you feel handicapped by a hearing problem?

☐ No ☐ Sometimes ☐ Yes

5. Does a hearing problem cause you difficulty when visiting friends, relatives or neighbours?

☐ No ☐ Sometimes ☐ Yes

6. Does a hearing problem cause you difficulty in the movies or in the theatre?

☐ No ☐ Sometimes ☐ Yes

7. Does a hearing problem cause you to have arguments with family members?

☐ No ☐ Sometimes ☐ Yes

8. Does a hearing problem cause you difficulty when listening to TV or radio?

☐ No ☐ Sometimes ☐ Yes

9. Do you feel that any difficulty with your hearing limits or hampers your personal or social life?

☐ No ☐ Sometimes ☐ Yes

10. Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?

☐ No ☐ Sometimes ☐ Yes

HHIA-S Score _____