NORTHERN VALLEY **ENT**

Hearing Health Assessment

Patient Name _____ Sex ☐ M ☐ F DOB _____ /_____ /_____
First Last MI MM DD YYYY

INSTRUCTIONS:

The purpose of the scale is to identify the problems your hearing loss may be causing you.
Check Yes, Sometimes, No or N/A for each question.
Do not skip a question if you avoid a situation because of a hearing problem.

	Yes	Sometimes	No	N/A
1. Does a hearing problem cause you to use the phone less often than you would like?	☐	☐	☐	☐
2. Does a hearing problem cause you embarrassment when meeting new people?	☐	☐	☐	☐
3. Does a hearing problem cause you to avoid groups of people?	☐	☐	☐	☐
4. Does a hearing problem make you irritable?	☐	☐	☐	☐
5. Does a hearing problem cause frustration when talking to members of your family?	☐	☐	☐	☐
6. Does a hearing problem cause you difficulty when attending a party?	☐	☐	☐	☐
7. Does a hearing problem cause you difficulty hearing/understanding co-workers, clients or customers?	☐	☐	☐	☐
8. Do you feel handicapped by a hearing problem?	☐	☐	☐	☐
9. Does a hearing problem cause you difficulty in the movies or theater?	☐	☐	☐	☐
10. Does a hearing problem cause you to be nervous?	☐	☐	☐	☐
11. Does a hearing problem cause you to visit friends, relatives or neighbors less often than you would like?	☐	☐	☐	☐
12. Does a hearing problem make it difficult to listen to TV or radio?	☐	☐	☐	☐
13. Does a hearing problem cause you to go shopping less often than you would like?	☐	☐	☐	☐
14. Does any problem or difficulty with your hearing upset you?	☐	☐	☐	☐
15. Does a hearing problem cause you to talk with family members less often than you would like?	☐	☐	☐	☐
16. Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	☐	☐	☐	☐
17. Does a hearing problem make it difficult to converse in a restaurant?	☐	☐	☐	☐
18. Does a hearing problem make you feel depressed?	☐	☐	☐	☐
19. Does a hearing problem make you uncomfortable when talking to friends?	☐	☐	☐	☐
20. Does a hearing problem make you feel left out when you're with a group of friends?	☐	☐	☐	☐
For clinician's use only: **YES** = 4 **SOMETIMES** = 2 **NO** = 0 *Total score* ____	*Total* ____	____	____	____

What are the top 3 environments you would like to hear better in?	**SCALE OF 1-4**	**PRE**	**POST**
1. _____			
2. _____			
3. _____			

Are there any specific features you are interested in for your hearing devices? _____

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