HEARING INVENTORY—HEARING AID PATIENT VERSION

Name: _____ Date: _____ Score: _____

It is very important for us to know how you would evaluate your hearing with the use of your current hearing aids when they are working at their best.

	YES	SOMETIMES	NO
1. While wearing your hearing aids, does a hearing problem cause you to feel embarrassed when you meet new people?	☐	☐	☐
2. Does a hearing problem cause you to feel frustrated when talking to members of your family?	☐	☐	☐
3. While wearing your hearing aids, do you have difficulty hearing when someone speaks in a whisper?	☐	☐	☐
4. While wearing your hearing aids, do you feel burdened by a hearing problem?	☐	☐	☐
5. While wearing your hearing aids, does a hearing problem cause you to misunderstand words when visiting family, friends, or neighbors?	☐	☐	☐
6. Does a hearing problem cause you to attend large group situations less often than you would like?	☐	☐	☐
7. While wearing your hearing aids, does a hearing problem cause you to have arguments with your family members?	☐	☐	☐
8. While wearing your hearing aids, does a hearing problem cause you difficulty when listening to the TV or Radio?	☐	☐	☐
9. While wearing your hearing aids, do you feel that your quality of hearing limits or hampers your personal life?	☐	☐	☐
10. While wearing your aids, does a hearing problem cause you difficulty when eating in restaurants with family or friends?	☐	☐	☐

How often do you wear your hearing aids?

□ Occasionally □ Few hours a day □ All day

How long have you owned your current hearing aid(s)?

□ 0-6 months □ 6-12 months □ 1-2 years □ 2-3 years
□ 3-4 years □ 4-5 years □ 5-10 years □ 10+ years