



PATIENT QUESTIONNAIRE

1. What is the reason for coming to our office? I, family or friends believe I have hearing loss
 I need a second opinion
 I want information about hearing devices.
 Other: Please specify.

2. Do you currently wear one or more hearing devices? Yes No

Please click on the button that best describes your hearing in the situations listed below and how often you are in these situations. (If you currently wear one or more hearing devices, please check the buttons describing how you hear with your hearing devices in.)

Listening Situations	How well do you hear in these situations?			How often are you in these situations?		
	Well	Fairly Well	Poorly	Often	Sometimes	Seldom
One-on-one conversations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Quiet room (1 -2 people)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Small groups (4-6 people)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Large social gatherings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Watching television	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
During religious services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In the car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
At meetings or lectures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In your work environment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
On the telephone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. Have you had any experience with hearing devices or the new listening devices?

- True False I have never worn hearing devices.
 True False I have never been to a hearing healthcare professional.
 True False I have tried hearing devices in the past but they didn't work out for me.
 True False I have hearing devices, but I only wear them occasionally, if at all.
 True False I have one or more hearing devices and I wear it/them all the time in my
 Right ear Left ear Both ears

4. How important are these factors to you in a new hearing device? Please rate each one.

Factor	Unimportant	Somewhat Unimportant	Neutral	Somewhat Important	Most Important
Overall Sound Quality	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Style or Appearance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cost	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reliability	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Invisibility	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5. On a scale of **1** to **10**, how concerned are you about doing something for your hearing **IF** a hearing loss is detected? (Please circle one number)

- 1** **2** **3** **4** **5** **6** **7** **8** **9** **10**
 Not Somewhat Concerned Very Extremely
 Concerned Concerned Concerned Concerned Concerned