



Hearing Inventory for Patient & Companion

Date _____

Patient Name: _____

Companion Name: _____ Relationship: _____

It is our mission to find the best personal solution for each individual's communication needs. We will only be successful in reaching this goal if we take the time to compile the following information about you. Please respond to the following statements by checking the appropriate response as it applies to you. Please complete the Patient portion first, and then have a companion respond to each statement.

Y = Yes; S = Sometimes; N = No	Patient			Companion		
	Y	S	N	Y	S	N
1. My hearing problem causes me (loved one) to feel embarrassed when meeting new people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. My hearing problem causes me (loved one) to feel frustrated when talking to family members.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I have difficulty hearing when someone speaks in a whisper.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I feel burdened by a hearing problem.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. My hearing problem causes me (loved one) difficulty when visiting friends, relatives, or neighbors.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. My hearing problem causes me (loved one) to attend large group situations less often than you would like.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. My hearing problem causes me (loved one) to have arguments with family members.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. My hearing problem causes me (loved one) difficulty when listening to TV or radio.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. My hearing problem causes me (loved one) difficulty with your hearing limits or hampers your personal or social life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. My hearing problem causes me (loved one) difficulty when in a restaurant with relatives or friends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please bring this with you for your appointment!

Adapted from HHIE