HILLCREST
HEARING & BALANCE CENTER
A DIVISION OF SOUTHWEST OHIO ENT SPECIALISTS

HEARING ASSESSMENT | YOUR COMPANION

Your Name: _____ **Date:** _____

Companion Name: _____

PLEASE HAVE YOUR COMPANION READ EACH QUESTION AND ANSWER "YES", "SOMETIMES", OR "NO" IN REGARDS TO YOUR HEARING LOSS.

	PLEASE CIRCLE YOUR ANSWER
1. Does a hearing problem cause your companion to feel embarrassed when meeting new people?	yes sometimes no
2. Does a hearing problem cause your companion to feel frustrated when talking to members of your family?	yes sometimes no
3. Does your companion have difficulty hearing when someone speaks in a whisper?	yes sometimes no
4. Does your companion feel handicapped by a hearing problem?	yes sometimes no
5. Does a hearing problem cause your companion difficulty when visiting friends, relatives or neighbors?	yes sometimes no
6. Does a hearing problem cause your companion to attend religious service, the movies or theater less often than they would like?	yes sometimes no
7. Does a hearing problem cause your companion to have arguments with family members?	yes sometimes no
8. Does a hearing problem cause your companion difficulty when listening to the TV or radio?	yes sometimes no
9. Do you feel that any difficulty with your companion's hearing limits or hampers their personal or social life?	yes sometimes no
10. Does a hearing problem cause your companion difficulty when in a restaurant with relatives or friends?	yes sometimes no