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

YOUR HEARING | SELF ASSESSMENT

Your Name: _____ **Date:** _____

PLEASE READ EACH QUESTION AND ANSWER "YES", "SOMETIMES" OR "NO"

(Answer as you would without using hearing instruments)

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