Hearing Device Questionnaire

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please answer the following:

|  |  |
| --- | --- |
| How many hours per day do you wear your hearing devices? |  |
| Do you have any concerns with comfort or retention? | Yes | No |
| If yes, please explain: |
| Do you have excessive feedback or whistling in one or both ears? | Yes | No |
| Do you clean your hearing devices thoroughly every day? | Yes | No |
| How well do you hear in the following situations: |
|  Conversations with 1 or 2 people: | Very Well | Good | Fair | Poor |
|  Watching television | Very Well | Good | Fair | Poor |
|  On the telephone | Very Well | Good | Fair | Poor |
|  At a noisy restaurant/party | Very Well | Good | Fair | Poor |
|  At a meeting/lecture | Very Well | Good | Fair | Poor |
|  At work | Very Well | Good | Fair | Poor |
|  At a house of worship or other social venue | Very Well | Good | Fair | Poor |
| On a scale of 1-10, with 1 being “Not at all Satisfied” and 10 being “Very Satisfied,” how satisfied are you with your current devices?[ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  5 [ ]  6 [ ]  7 [ ]  8 [ ]  9 [ ]  10 Not at all Satisfied Satisfied Very Satisfied |
| If your answer was less than 5, please explain: |

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