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: | | | | |

03/2025