

HI Form – Patient

Name: _____ Date: _____

Instructions: Check **Unaided** if you do not wear hearing aids, or select **Aided** if you wear either one or two hearing aids. It is assumed that your responses to the questionnaire relate to your perceptions of your hearing under the specific condition indicated.

Unaided Aided

Finally, select **No**, **Sometimes**, or **Yes** in response to each question. If you do not engage in a particular activity, respond according to the way you feel you would respond in that situation.

1. Does a hearing problem cause you to feel embarrassed when you meet new people?
 NO SOMETIMES YES
2. Does a hearing problem cause you to feel frustrated when talking to members of your family?
 NO SOMETIMES YES
3. Do you have difficulty hearing or understanding co-workers, clients, or customers?
 NO SOMETIMES YES
4. Do you feel handicapped by a hearing problem?
 NO SOMETIMES YES
5. Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?
 NO SOMETIMES YES
6. Does a hearing problem cause you difficulty in the movies or in the theater?
 NO SOMETIMES YES
7. Does a hearing problem cause you to have arguments with family members:
 NO SOMETIMES YES
8. Does a hearing problem cause you difficulty when listening to TV or radio?
 NO SOMETIMES YES
9. Do you feel that any difficulty with your hearing limits or hampers your personal or social life?
 NO SOMETIMES YES
10. Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?
 NO SOMETIMES YES