HI Form –Companion

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