Hearing HealthCare Centers

Patient Name: _____ Date: _____

Perception of Hearing Questionnaire

Please circle the answer that best describes how often these statements apply to you:

Does a hearing problem cause you to feel embarrassed when you meet new people?	YES	SOMETIMES	NO
Does a hearing problem cause you to feel frustrated when talking to members of your family?	YES	SOMETIMES	NO
Do you have difficulty hearing when someone speaks in a whisper?	YES	SOMETIMES	NO
Do you feel handicapped by a hearing problem?	YES	SOMETIMES	NO
Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?	YES	SOMETIMES	NO
Does a hearing problem cause you to attend religious services less often than you would like?	YES	SOMETIMES	NO
Does a hearing problem cause you to have arguments with family members?	YES	SOMETIMES	NO
Does a hearing problem cause you difficulty when listening to TV or radio?	YES	SOMETIMES	NO
Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	YES	SOMETIMES	NO
Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	YES	SOMETIMES	NO
Does a hearing problem cause you to feel like hearing and listening cause you extra effort?	YES	SOMETIMES	NO
Are you aware of using visual cues or compensation (ie. Lip-reading) to help you hear better?	YES	SOMETIMES	NO

Score:_____