

## HEARING ASSESSMENT

| 1. What is y       | our hearing  | g aid experie | nce?           |               |               |                |                          |                |                     |
|--------------------|--------------|---------------|----------------|---------------|---------------|----------------|--------------------------|----------------|---------------------|
| ☐ I have a h       | nearing devi | ce and use it | regularly on   | theright      | ear left ea   | r.             |                          |                |                     |
| ☐ I have a h       | nearing devi | ce, but don't | use it, or use | e it only occ | asionally.    |                |                          |                |                     |
| ☐ I tried a h      | earing devi  | ce but return | ed it for crec | lit.          |               |                |                          |                |                     |
| ☐ I have inc       | quired abou  | t hearing dev | ices at anoth  | er office(s), | but did not p | ourchase at th | at time.                 |                |                     |
| ☐ I have ne        | ver used a h | nearing devic | е.             |               |               |                |                          |                |                     |
| 2. Rank the        | following i  | n order of in | portance to    | you regard    | ding a hearir | ng device, w   | ith 1 being <sup>.</sup> | the most i     | important           |
| and 5 the le       | ast importa  | ant:          |                |               |               |                |                          |                |                     |
| _                  | _ Sound Qu   | ality/Clarity | Durability     | /Reliability  | Cost          | Appearance     | Bluetoo                  | th Connec      | tivity              |
| 3. What mot        | tivated you  | ı to make an  | appointme      | nt?           |               |                |                          |                |                     |
| 4. On a scal       | e from one   | to ten how    | much is you    | r hearing lo  | ss impacting  | your daily     | <b>routine?</b> (Plea    | ase circle one | )                   |
| 1<br>Not At<br>All | 2            | 3             | 4              | 5             | 6             | 7              | 8                        | 9              | 10<br>Significantly |

5. Please check the box which corresponds to your ability to hear in situations listed and check how often you are in that situation.

| LISTENING SITUATION        | HOW WELI | DO YOU | HEAR IN THIS<br>N? | HOW OFTEN ARE YOU IN THIS SITUATION? |           |       |  |
|----------------------------|----------|--------|--------------------|--------------------------------------|-----------|-------|--|
| Quiet Room (1 to 2 people) | Poor     | Fair   | Good               | Rarely                               | Sometimes | Often |  |
| Restaurants                | Poor     | Fair   | Good               | Rarely                               | Sometimes | Often |  |
| Car                        | Poor     | Fair   | Good               | Rarely                               | Sometimes | Often |  |
| Television                 | Poor     | Fair   | Good               | Rarely                               | Sometimes | Often |  |
| Church                     | Poor     | Fair   | Good               | Rarely                               | Sometimes | Often |  |
| Meeting/ Lecture           | Poor     | Fair   | Good               | Rarely                               | Sometimes | Often |  |
| Work Place                 | Poor     | Fair   | Good               | Rarely                               | Sometimes | Often |  |
| Telephone Call             | Poor     | Fair   | Good               | Rarely                               | Sometimes | Often |  |
| Large Social Gatherings    | Poor     | Fair   | Good               | Rarely                               | Sometimes | Often |  |