

Patient Name:

Date:

### Hearing Screening Questionnaire-Patient Version

**Instructions:** Answer Yes, No, or Sometimes for each question. Do not skip a question if you avoid a situation because of your hearing ability. If you use a hearing aid, please answer according to the way you hear with the hearing with the aid.

1. Does a hearing problem cause you to feel embarrassed when you meet new people?  
☐ Yes ☐ No ☐ Sometimes
2. Does a hearing problem cause you to feel frustrated when talking to members of your family?  
☐ Yes ☐ No ☐ Sometimes
3. Do you have difficulty hearing when someone speaks in a whisper?  
☐ Yes ☐ No ☐ Sometimes
4. Do you feel handicapped by a hearing problem?  
☐ Yes ☐ No ☐ Sometimes
5. Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?  
☐ Yes ☐ No ☐ Sometimes
6. Does a hearing problem cause you to attend religious services less often than you would like?  
☐ Yes ☐ No ☐ Sometimes
7. Does a hearing problem cause you to have arguments with family members?  
☐ Yes ☐ No ☐ Sometimes
8. Does a hearing problem cause you difficulty when listening to TV or radio?  
☐ Yes ☐ No ☐ Sometimes
9. Do you feel that any difficulty with your hearing limits of hampers your personal or social life?  
☐ Yes ☐ No ☐ Sometimes
10. Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?  
☐ Yes ☐ No ☐ Sometimes

To be completed by Clinic Staff:

**Scoring:** No = 0; Sometimes = 2; Yes = 4.

**Interpretation of Total Score:** 0-8 = no handicap; 10-24 = mild to moderate handicap; 26-40 = severe handicap.

\* Adapted from: Ventry I, Weinstein B. Identification of elderly people with hearing problems. ASHA. 1983; 25:37-42.

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**Please list the top three listening situations in which you would like to hear better:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_