

# Communication Abilities - Patient

Patient Name \_\_\_\_\_  
First MI Last

Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM DD YYYY

How much difficulty do you have hearing in the following situations?

	None	Slight	Moderate	Quite A Lot	Very Much	Not Relevant
One-on-one conversation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conversations in small groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conversations in large groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outdoors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concerts or movies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Places of worship or lectures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phone: Landline	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Phone: Mobile	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have ringing in the ears (tinnitus)?  Yes  No  
 If so, does it bother you?  Yes  No  
 What is your desired lifestyle? *Please select one.*  Private  Quiet  Active  Dynamic  
 Does the companion agree?  Yes  No

What are the top three environments in which you would like to hear better?

**SCALE 1-4**

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

Are there any specific features you are interested in for your hearing devices?

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