YOUR HEARING | SELF ASSESSMENT

THE FELDMAN HEARING STUDIOS

Your Name: _____ Date: _____

INSTRUCTIONS: Please read each question and answer "Yes," "Sometimes" or "No," as appropriate. Please circle your answer. Answer the questions as you would without using hearing instruments.

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

CLINICAL USE ONLY (HHIEÐS): [Y(4), S(2), N(0)], [1E,2E,3S,4E,5S,6S,7E,8S,9E,10S]

Ventry, I. & Weinstein, B. The Hearing Handicap Inventory for the Elderly: A new tool. Ear Hear. 3, 128-134 (1982)