

HEARING HEALTH QUICK TEST

Name: _____ Patient# _____ Date: _____

Circle YES, NO or Sometimes for each question.

1) Do you find it difficult to follow a conversation in a noisy restaurant or crowded room?

YES NO SOMETIMES

2) Do you sometimes feel that people are mumbling or not speaking clearly?

YES NO SOMETIMES

3) Do you sometimes have difficulty understanding speech on the telephone?

YES NO SOMETIMES

4) Do you experience ringing or noises in your ears?

YES NO SOMETIMES

5) Have you had any significant noise exposure during work, recreation or military service?

YES NO

6) If you are currently using hearing aids, are you satisfied with their performance?

YES NO N/A

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