

Complete Hearing



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Instructions: Listed below are statements regarding different listening environments. For each statement, please check the appropriate response: Yes / No / Sometimes (ST). If you currently wear hearing devices, please answer each question according to your experience with your hearing devices on.

1. When I am having a one-on-one conversation in quiet, I have difficulty understanding.....Yes No ST
2. I have to ask unfamiliar people to repeat themselves.....Yes No ST
3. I have difficulty understanding conversation when several people are talking.....Yes No ST
4. When I'm at a restaurant or in the dining hall, understanding speech is difficult.....Yes No ST
5. At times, I miss information when I'm listening to a lecture or sermon.....Yes No ST
6. At times, I miss information when in a large group or meeting.....Yes No ST
7. I have trouble understanding others when in the car.....Yes No ST
8. I have difficulty when listening to TV or radio.....Yes No ST
9. I have difficulty hearing on the phone.....Yes No ST
Which ear do you use the telephone on? Right Left
Do you use a cell phone? Yes No Which brand: _____
10. I wish people would talk louder.....Yes No ST
11. I wish people would talk clearer.....Yes No ST
12. I have difficulty hearing women or children's voices.....Yes No ST
13. I have difficulty hearing men's voices.....Yes No ST
14. Hearing difficulties cause me to have disagreements with my family or friends.....Yes No ST
15. My hearing difficulties restrict my personal or social life.....Yes No ST

Please list the top three situations where you would most like to hear better:

- 1) _____
- 2) _____
- 3) _____

Please continue on other side →

Instructions: What is your most important consideration regarding hearing devices? Rank in order the following factors with 1 as the most important and 5 as the least important. Place an X on the line if the item has no importance to you.

- _____ Inconspicuous Appearance
- _____ Understanding Speech Better
- _____ Benefit in Noise Environments
- _____ Cost
- _____ Service

Instructions: Do you prefer hearing devices that: (Please check one.)

- _____ Are completely automatic, therefore, you do not have to make any adjustments to them.
- _____ Allow you to adjust the volume and change the listening programs as you see fit.
- _____ No Preferences.

Amplification History:

Do you currently or have you worn hearing devices? NO YES If yes, which ear: Right Left Both

If no, please skip the remainder of the questionnaire and sign at the bottom of this page.

How long have you been wearing hearing devices? Less than 1 year 1-10 years More than 10 years

What year did you buy your current hearing devices? _____

If known, please list the manufacturer, model and/or style of hearing device that you currently wear:

Approximately how many hours a day do you wear your hearing devices? _____

How satisfied are you with your hearing devices? (Check one)

- Very Satisfied Satisfied Neutral Dissatisfied Very Dissatisfied

Please explain: _____

Thank you for taking the time to fill out this questionnaire. Your responses will assist us in providing you with the best hearing health care. Please sign below indicating that the information in this form has been read, understood, filled out completely & accurately to the best of your knowledge.

Printed name: _____ DOB: _____

Signature: _____ Date: _____