Comprehensive
EAR & HEARING
Grand Haven • Zeeland • Holland

Name_____Birthdate_____Age_____

1.	Do you suspect you have a hearing loss?	Yes	No
2.	Is one ear worse than the other? Which one? _____	Yes	No
3.	Have you had any pain or discomfort in your ears in the past 90 days?	Yes	No
4.	Have you had any drainage from your ears in the last 90 days?	Yes	No
5.	Do you have tinnitus (ringing or other noises) in your ears?	Yes	No
6.	Do you suffer from dizzy spells?	Yes	No
7.	Have there been any sudden changes in your hearing in the last 90 days?	Yes	No
8.	Do you have hypertension (High Blood Pressure)?	Yes	No

HEARING HANDICAP INVENTORY (Ventry & Weinstein, 1972)

1.	Does a hearing problem cause you to feel embarrassed when meeting 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 hearing problems 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 or 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

HEARING HANDICAP INVENTORY SCORE	**PERCEIVED HANDICAP**
0-8	**No handicap / No referral**
10-24	**Mild – Moderate Handicap**
26-40	**Severe Handicap**

Please list the following hearing aid qualities in numerical order with #1 being the most important to you and #4 being the least important.

COST____ APPEARANCE____ COMFORT____ HEARING BETTER____