

# Companion Questionnaire

Name \_\_\_\_\_ Patient Name \_\_\_\_\_

Relation to Patient \_\_\_\_\_ Date \_\_\_\_\_

In our professional experience, we have found that many of our patients describe hearing loss as the perception of Sound Voids® that affect not only their normal daily routines but the lives of those around them. We would like to ask you a few situational questions to better understand your companion's listening lifestyle and how we might improve their quality of life.

## How often does a hearing problem...

	Always	Sometimes	Never
Make it difficult for your companion to converse on the telephone?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cause you to complain that your companion turns up the television or radio too loud?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cause your companion to have difficulty following conversations in a restaurant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Limit or hamper your companion's personal or social life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cause your companion to have to ask people to repeat themselves?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cause your companion to have difficulty hearing when in the presence of background noise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cause your companion to have difficulty hearing women's or children's voices?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cause your companion to hear people speak but fail to understand what they are saying?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cause your companion to feel as though others mumble?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cause your companion to feel stressed or tired when listening for long periods of time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Please provide the top three listening situations where you would like your companion to hear better.

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

## Please select your companion's current and (if different) desired lifestyles.

### Active Lifestyle (Frequent Background Noise)

Current  Desired

### Quiet Lifestyle (Limited Background Noise)

Current  Desired

### Casual Lifestyle (Occasional Background Noise)

Current  Desired

### Very Quiet Lifestyle (Rare Background Noise)

Current  Desired

# Companion Questionnaire

If your companion does not currently use technology, please skip this section.

## My companion has difficulty hearing when using technology...

	Always	Sometimes	Never	N/A
1. While in background noise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. In the car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. On the phone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. In a conference room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. In a restaurant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. While listening to music	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. While watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. In group conversations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. In conversations with their spouse or family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. In conversations with women or children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional comments \_\_\_\_\_

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