

Companion Questionnaire

Name _____ Patient Name _____

Relation to Patient _____ Date _____

Hearing loss affects not only your normal daily routine, but the lives of those around you, as well. We would like to ask you a few questions to better understand your companion's listening lifestyle and how we might improve their quality of life.

Does a hearing problem:

Always Sometimes Never

Make it difficult for your companion to converse on the telephone?	<input type="checkbox"/> A	<input type="checkbox"/> S	<input type="checkbox"/> N
Cause you to complain that your companion turns up the TV or radio too loud?	<input type="checkbox"/> A	<input type="checkbox"/> S	<input type="checkbox"/> N
Cause your companion to have difficulty following conversations in a restaurant?	<input type="checkbox"/> A	<input type="checkbox"/> S	<input type="checkbox"/> N
Limit or hamper your companion's personal or social life?	<input type="checkbox"/> A	<input type="checkbox"/> S	<input type="checkbox"/> N
Cause your companion to have to ask people to repeat themselves?	<input type="checkbox"/> A	<input type="checkbox"/> S	<input type="checkbox"/> N
Cause your companion to have difficulty hearing when in the presence of background noise?	<input type="checkbox"/> A	<input type="checkbox"/> S	<input type="checkbox"/> N
Cause your companion to have difficulty hearing women's or children's voices?	<input type="checkbox"/> A	<input type="checkbox"/> S	<input type="checkbox"/> N
Cause your companion to hear people speak, but fail to understand what they are saying?	<input type="checkbox"/> A	<input type="checkbox"/> S	<input type="checkbox"/> N
Cause your companion to feel as though others mumble?	<input type="checkbox"/> A	<input type="checkbox"/> S	<input type="checkbox"/> N
Cause your companion to feel stressed or tired when listening for long periods of time?	<input type="checkbox"/> A	<input type="checkbox"/> S	<input type="checkbox"/> N

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:

Dynamic Lifestyle (Frequent Background Noise)

Current Desired

Active Lifestyle (Occasional Background Noise)

Current Desired

Quiet Lifestyle (Limited background Noise)

Current Desired

Private Quiet Lifestyle (Rare Background Noise)

Current Desired

My companion's Current Technology performance is satisfactory:

Always Sometimes Never

While in background noise	<input type="checkbox"/> A	<input type="checkbox"/> S	<input type="checkbox"/> N
At religious services	<input type="checkbox"/> A	<input type="checkbox"/> S	<input type="checkbox"/> N
At the movies	<input type="checkbox"/> A	<input type="checkbox"/> S	<input type="checkbox"/> N
In the car	<input type="checkbox"/> A	<input type="checkbox"/> S	<input type="checkbox"/> N
On the phone	<input type="checkbox"/> A	<input type="checkbox"/> S	<input type="checkbox"/> N
In a conference room	<input type="checkbox"/> A	<input type="checkbox"/> S	<input type="checkbox"/> N
In a restaurant	<input type="checkbox"/> A	<input type="checkbox"/> S	<input type="checkbox"/> N
While listening to music	<input type="checkbox"/> A	<input type="checkbox"/> S	<input type="checkbox"/> N
While watching TV	<input type="checkbox"/> A	<input type="checkbox"/> S	<input type="checkbox"/> N
In group conversations	<input type="checkbox"/> A	<input type="checkbox"/> S	<input type="checkbox"/> N
In conversations with their spouse	<input type="checkbox"/> A	<input type="checkbox"/> S	<input type="checkbox"/> N
In conversations with children	<input type="checkbox"/> A	<input type="checkbox"/> S	<input type="checkbox"/> N

Additional Comments _____
