

HEARING HISTORY

WITHOUT HEARING AIDS

YES NO

- | | | |
|--------------------------|--------------------------|--------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you find yourself asking people to repeat what they have said? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you sometimes hear the words without understanding them? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have more difficulty hearing if you cannot see the speaker? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have more difficulty hearing because of background noise? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do others complain that the TV is set too loud? |

If applicable, WITH HEARING AIDS

YES NO

- | | |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> |

LISTENING SITUATIONS

In which situations would you like to hear better? *Check all that apply.*

- | | | | |
|--------------------------------------------------|---------------------------------------------|---------------------------------------|------------------------------------------|
| <input type="checkbox"/> One-on-One Conversation | <input type="checkbox"/> Religious Services | <input type="checkbox"/> Large Groups | <input type="checkbox"/> In small groups |
| <input type="checkbox"/> Workplace | <input type="checkbox"/> Car | <input type="checkbox"/> Outdoors | <input type="checkbox"/> Telephone |
| <input type="checkbox"/> Meetings | <input type="checkbox"/> Movie/Theatre | <input type="checkbox"/> Restaurant | <input type="checkbox"/> Television |
| <input type="checkbox"/> Other: _____ | | | |

HEARING PREFERENCES AND EXPECTATIONS

- | | | | | |
|-----------------------------|----------------------------------------------|---------------------------------------------|----------------------------------|--------------------------------------|
| Hearing in Quiet: | <input type="checkbox"/> Extremely Important | <input type="checkbox"/> Slightly Important | <input type="checkbox"/> Neutral | <input type="checkbox"/> Unimportant |
| Hearing in Noise: | <input type="checkbox"/> Extremely Important | <input type="checkbox"/> Slightly Important | <input type="checkbox"/> Neutral | <input type="checkbox"/> Unimportant |
| Hearing Aid Expense: | <input type="checkbox"/> Extremely Important | <input type="checkbox"/> Slightly Important | <input type="checkbox"/> Neutral | <input type="checkbox"/> Unimportant |
| Cosmetic Appearance: | <input type="checkbox"/> Extremely Important | <input type="checkbox"/> Slightly Important | <input type="checkbox"/> Neutral | <input type="checkbox"/> Unimportant |

How confident are you in your knowledge regarding hearing aid technology?

- | | | | |
|-----------------------------------------|---------------------------------------------|----------------------------------|----------------------------------------|
| <input type="checkbox"/> Very Confident | <input type="checkbox"/> Somewhat Confident | <input type="checkbox"/> Neutral | <input type="checkbox"/> Not Confident |
|-----------------------------------------|---------------------------------------------|----------------------------------|----------------------------------------|

How much benefit do you expect to gain from hearing aids?

- | | | | |
|----------------------------------------------|-------------------------------------------|----------------------------------|-------------------------------------|
| <input type="checkbox"/> Significant Benefit | <input type="checkbox"/> Moderate Benefit | <input type="checkbox"/> Neutral | <input type="checkbox"/> No Benefit |
|----------------------------------------------|-------------------------------------------|----------------------------------|-------------------------------------|

How motivated are you to wear hearing aids?

- | | | | |
|-------------------------------------------|---------------------------------------------|----------------------------------|----------------------------------------|
| <input type="checkbox"/> Highly Motivated | <input type="checkbox"/> Slightly Motivated | <input type="checkbox"/> Neutral | <input type="checkbox"/> Not Motivated |
|-------------------------------------------|---------------------------------------------|----------------------------------|----------------------------------------|

How confident are you that you will be successful with hearing aids?

- | | | | |
|-----------------------------------------|---------------------------------------------|----------------------------------|----------------------------------------|
| <input type="checkbox"/> Very Confident | <input type="checkbox"/> Somewhat Confident | <input type="checkbox"/> Neutral | <input type="checkbox"/> Not Confident |
|-----------------------------------------|---------------------------------------------|----------------------------------|----------------------------------------|

HEARING AID PREFERENCES

Would you prefer hearing aids that:

- Are completely automatic so that you do not have to make any adjustments.
- Allow you to adjust the volume and make program selections as needed.
- Not sure or no preference.

If results show that hearing aids would be beneficial, are you ready to try amplification?

Please rate your readiness on this 1-10 scale.

Not Ready 1 2 3 4 5 6 7 8 9 10 Absolutely Ready

CURRENT HEARING AID USERS

How long have you worn hearing aids? _____ Do you wear one or two? _____

How old are your current hearing aids? _____ How often do you wear your hearing aids? _____

What do you like about your hearing aids? _____

What would you want to improve about your hearing aids? _____