

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 _____

