

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

	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.

 **Very Quiet**
Rare
Background Noise

Current
 Desired

 **Quiet**
Limited
Background Noise

Current
 Desired

 **Casual**
Occasional
Background Noise

Current
 Desired

 **Active**
Frequent
Background Noise

Current
 Desired

Companion Questionnaire

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

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
