Pinnacle ENT ASSOCIATES LLC

VALLEY FORGE EAR, NOSE & THROAT ASSOCIATES DIVISION

Communication Abilities - Patient

Patient Name _____ Date _____ / _____ / _____
First MI Last MM DD YYYY

How much difficulty do you have hearing in the following situations?

	None	Slight	Moderate	Quite A Lot	Very Much	Not Relevant
One-on-one conversation	☐	☐	☐	☐	☐	☐
Conversations in small groups	☐	☐	☐	☐	☐	☐
Conversations in large groups	☐	☐	☐	☐	☐	☐
Outdoors	☐	☐	☐	☐	☐	☐
Concerts or movies	☐	☐	☐	☐	☐	☐
Places of worship or lectures	☐	☐	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐	☐	☐
Phone: Landline	☐	☐	☐	☐	☐	☐
Phone: Mobile	☐	☐	☐	☐	☐	☐
Other (specify) _____	☐	☐	☐	☐	☐	☐

_____

Do you have ringing in the ears (tinnitus)?	☐ Yes	☐ No		
If so, does it bother you?	☐ Yes	☐ No		
What is your desired lifestyle? *Please select one.*	☐ Private	☐ Quiet	☐ Active	☐ Dynamic
Does the companion agree?	☐ Yes	☐ No		

What are the top three environments in which you would like to hear better?

1. _____
2. _____
3. _____

Are there any specific features you are interested in for your hearing devices?

_____

_____

_____

_____

_____