



COMPANION QUESTIONNAIRE

Name _____ Patient's Name _____

Relation to Patient _____ Today's Date _____

LIFESTYLE

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 others to complain that they turn up the television or radio too loud?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cause them difficulty following conversation at a restaurant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Limit or hamper their personal or social life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cause them to have to ask people to repeat themselves?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cause them difficulty hearing when you are in the presence of background noise?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cause them to have difficulty hearing women's or children's voices?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cause them to hear people speak but fail to understand what they are saying?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cause them to feel as though others mumble?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cause them to feel stressed or tired when listening for long periods of time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE SELECT THEIR CURRENT AND (IF DIFFERENT) DESIRED LIFESTYLE

- | | | |
|--|----------------------------------|----------------------------------|
| Dynamic Lifestyle (Frequent Background Noise) | Current <input type="checkbox"/> | Desired <input type="checkbox"/> |
| Active Lifestyle (Limited Background Noise) | Current <input type="checkbox"/> | Desired <input type="checkbox"/> |
| Social Lifestyle (Occasional Background Noise) | Current <input type="checkbox"/> | Desired <input type="checkbox"/> |
| Quiet Lifestyle (Rare Background Noise) | Current <input type="checkbox"/> | Desired <input type="checkbox"/> |

LISTENING ENVIRONMENT

Check activities they currently participate in:

- | | | |
|--------------------------------------|--|---|
| <input type="checkbox"/> Work/Office | <input type="checkbox"/> Watching TV | <input type="checkbox"/> Talking in groups |
| <input type="checkbox"/> Outdoors | <input type="checkbox"/> On the phone | <input type="checkbox"/> Crowded/noisy places |
| <input type="checkbox"/> Concerts | <input type="checkbox"/> Business meetings | <input type="checkbox"/> Conversations with soft voices |
| <input type="checkbox"/> Lectures | <input type="checkbox"/> Exercise activities | <input type="checkbox"/> Place of worship |

Please tell us where you would like your companion to hear better:

1. _____
2. _____
3. _____

IF AMPLIFICATION IS DEEMED NECESSARY, PLEASE CHECK WHAT IS MOST IMPORTANT TO YOU AND YOUR COMPANION

- | | | |
|--|---|--|
| <input type="checkbox"/> Discreet design | <input type="checkbox"/> Ease of use | <input type="checkbox"/> Minimal amount of maintenance
(i.e; change battery, change programs, cleaning) |
| <input type="checkbox"/> Expense | <input type="checkbox"/> Ability to wear in most situations
(i.e; theaters, movies, on the phone, during exercise) | |

COMPANION QUESTIONNAIRE

If your companion does not currently use hearing instruments, please skip this section

MY COMPANION'S CURRENT TECHNOLOGY LEVEL IS SATISFACTORY...	Always	Sometimes	Never
While in background noise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
On the phone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a conference room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a restaurant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
While listening to music	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
While watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In group conversations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In conversations with their spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In conversations with women and children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>