Patient Assessment of Communication Abilities

Name: **Date:** **Aided or Unaided (circle one)**

Alternative: Are you currently wearing Hearing Aids? Y/N

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

	No difficulty	**Slight difficulty**	**Moderate difficulty**	**Quite a lot of difficulty**	**Very much difficulty**	**Not Relevant**
One-on-one conversation	☐	☐	☐	☐	☐	☐
Conversation in small groups	☐	☐	☐	☐	☐	☐
Conversation in large groups	☐	☐	☐	☐	☐	☐
Watching TV	☐	☐	☐	☐	☐	☐
Restaurant/café	☐	☐	☐	☐	☐	☐
Phone	☐	☐	☐	☐	☐	☐

Other: _______________

If you have difficulty with your hearing, please rank order the top three listening situations where it seems to be a problem:

Alternative: Please rank order the three listening situations that you would like to hear better:

1. ____________________
2. ____________________
3. ____________________