



Hearing Inventory "HI" for Companion

Name _____ Date _____ HI Score _____

Patient _____ Relationship to Patient _____

At Sonus, it is our mission to find the best personal solution for each individual's communication needs. We will only be successful in reaching this goal if we take the time to compile the following information from those closest to the patient...you!

Please answer the following questions by checking the appropriate response.

	Yes	Sometimes	No
1. Have you observed a situation where a hearing problem caused him/her to feel embarrassed when meeting new people?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you feel a hearing problem causes him/her to feel frustrated when talking to members of his/her family?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you noticed that he/she has difficulty hearing when someone speaks in a whisper?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you believe he/she is burdened by a hearing problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you concerned that a hearing problem causes him/her difficulty when visiting friends, relatives or neighbors?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you think that a hearing problem causes him/her to attend large group situations less often than they would like?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever felt that a hearing problem causes him/her to have arguments with family members?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you noticed that a hearing problem causes him/her difficulty when listening to TV or radio?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Are you concerned that any difficulty with his/her hearing limits or hampers their personal or social life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you observed that a hearing problem causes him/her difficulty when in a restaurant with relatives or friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Adapted from HHIE