

Pt. Name: \_\_\_\_\_ Initial Evaluation Date: \_\_\_\_\_

Relationship to Pt. \_\_\_\_\_

### HHIE Screen

Answer YES, NO or SOMETIMES for each question. Do not skip a question if you avoid a situation because of a hearing problem. If you use hearing aids, please answer according to the way you hear with the aids.

	Initial Evaluation			F/U Evaluation Date: _____
	Yes	No	Sometimes	
1. Does a hearing problem cause you to feel embarrassed when you meet new people?	[ ]	[ ]	[ ]	_____
2. Does a hearing problem cause you to feel frustrated when talking to members of your family?	[ ]	[ ]	[ ]	_____
3. Do you have difficulty hearing when someone speaks in a whisper?	[ ]	[ ]	[ ]	_____
4. Do you feel handicapped by a hearing problem?	[ ]	[ ]	[ ]	_____
5. Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?	[ ]	[ ]	[ ]	_____
6. Does a hearing problem cause you to attend religious services less often than you would like?	[ ]	[ ]	[ ]	_____
7. Does a hearing problem cause you to have arguments with family members?	[ ]	[ ]	[ ]	_____
8. Does a hearing problem cause you difficulty when listening to TV or radio?	[ ]	[ ]	[ ]	_____
9. Do you feel any difficulty with your hearing limits or hampers your personal or social life?	[ ]	[ ]	[ ]	_____
10. Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	[ ]	[ ]	[ ]	_____
	_____	_____	_____	_____