

Hearing Handicap Inventory

Please answer all questions as they relate to your hearing **WITHOUT** hearing aids.

Date: _____	Name: _____			
Symptom	Rarely (Less than monthly)	Sometimes (At least monthly)	Often (At least weekly)	Always (At least daily)
Does a hearing problem cause you to feel embarrassed when meeting new people?	___	___	___	___
Does a hearing problem cause you to feel frustrated when talking to members of your family?	___	___	___	___
Do you have difficulty hearing when someone whispers?	___	___	___	___
Do you feel handicapped by a hearing problem?	___	___	___	___
Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?	___	___	___	___
Does a hearing problem cause you to attend religious services less often than you would like?	___	___	___	___
Does a hearing problem cause you to have arguments with family members?	___	___	___	___
Does a hearing problem cause you difficulty when listening to TV or radio?	___	___	___	___
Do you feel that your hearing limits or hampers your personal or social life?	___	___	___	___
Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	___	___	___	___