Contact

Date

PATIENT INFORMATION

Name:

First

Last

Age

HHQ12 QUESTIONNAIRE

Please complete below 12 questions. Click circle to make rating selection.

	Never	Rarely	Sometimes	Often	Almost always
1. How often does your hearing difficulty restrict the things you do?					
2. How often do you feel worried or anxious because of your hearing difficulty?					
3. As a result of your hearing difficulty, how often do you feel embarrassment when in the company of other people?					
4. How often is your self-confidence affected by your hearing difficulty?					
5. How often does your hearing difficulty make you feel nervous or uncomfortable?					
6. How often does any difficulty with your hearing make you feel self-conscious?					
7. How often does your difficulty with your hearing affect the way you feel about yourself?					
8. How often are you inconvenienced by your hearing difficulty?					
9. How often do you feel inclined to avoid social situations because of your hearing difficulty?					
10. How often do you feel cut off from things because of your hearing difficulty?					
11. How often does your hearing difficulty restrict your personal life?					
12. How often do you feel tense and tired because of your hearing difficulty?					

Minimum: Maximum: Average: Total:

Source: The Speech, Spatial and Qualities of Hearing Scale (SSQ). Gatehouse S, Noble W. Int J Audiol. 2004 Feb; 43(2):85-99.. Form design copyright of Blueprint Solutions LLC.