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Hearing Loss Questionnaire

The following questions concern your hearing loss. Please read each of the following questions carefully and answer them to the best of your knowledge. All responses will remain confidential.

Name:_____ Today's Date:_____

1.) **How old were you when you first noticed your hearing loss? _____**

2.) **How old were you when your hearing loss was diagnosed? _____**

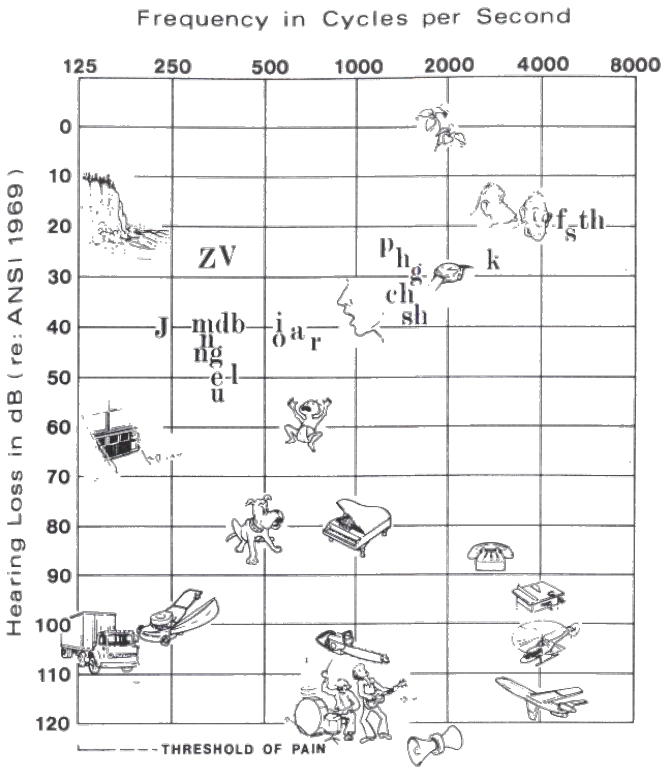
3.) **What is the cause of your hearing loss**?
- ❑ Autoimmune inner ear disease
- ❑ Very loud noise
- ❑ Ear infection
- ❑ Acoustic neuroma (e.g., tumor)
- ❑ Genetic
- ❑ Presbycusis (age-related)
- ❑ Otosclerosis (abnormal growth of bone in ear)
- ❑ Ménière's disease
- ❑ Childhood disease/illness
- ❑ Physical head injury or trauma (e.g., accident)
- ❑ Medication
- ❑ Unknown
- ❑ Other (describe):_____

4.) **Your ear(s) affected by the hearing loss:**
- ❑ Both ears
- ❑ Right ear only
- ❑ Left ear only

5.) **What is your degree of hearing loss in your right ear**?
- ❑ No hearing loss
- ❑ Don't know
- ❑ Mild (21-40db)
- ❑ Moderate (41-60 db)
- ❑ Moderate-severe (61-70 db)
- ❑ Severe (71-89 db)
- ❑ Profound (90+ db)

6.) **What is your degree of hearing loss in your left ear**?

- ❑ No hearing loss
- ❑ Don't know
- ❑ Mild (21-40db)
- ❑ Moderate (41-60 db)
- ❑ Moderate-severe (61-70 db)
- ❑ Severe (71-89 db)
- ❑ Profound (90+ db)



7.) **Which statement best describes your hearing loss?**

- ❑ My hearing continues to decline
- ❑ My hearing loss has been stabilized
- ❑ My hearing is improving

8.) **Which of these terms best describes you**: (Please choose one)

- ❑ Hearing
- ❑ Hearing-impaired
- ❑ Hard-of-Hearing
- ❑ deaf
- ❑ Deaf (Culturally deaf)

9.) **Do you have any additional disabilities**? ❑ No ❑ Yes

If Yes, Please specify:

- ❑ ADHD or ADD
- ❑ Vision Problems
- ❑ Learning Disability
- ❑ Neurological conditions (e.g., Tourette's Syndrome)
- ❑ Genetic disorders
- ❑ Muscular Disorders
- ❑ Other, please explain_____

_____

10.) **Are you experiencing Tinnitus** (i.e., ringing, swishing, or other type of noise that seems to originate in the ear or head)?

- ❑ Yes
- ❑ No

If you answered YES to number 10, please continue with question number 11.
If you answered NO to number 10, please continue with number 19.

11.) **The purpose of this questionnaire is to find out whether the noises in your ears/head have had any effect on your mood, habits or attitudes. Please mark the answer with an X that applies to you for each statement.**

		True	Partly True	Not True
1.	I am aware of the noises from the moment I get up to the moment I sleep			
2.	Because of the noises I worry that there is something seriously wrong with my body			
3.	If the noises continue my life will not be worth living			
4.	I am more irritable with my family and friends because of the noises			
5.	I worry that the noises might damage my physical health			
6.	I find it harder to relax because of the noises			
7.	My noises are often so bad that I cannot ignore them			
8.	It takes me longer to get to sleep because of the noises			
9.	I am more liable to feel low because of the noises			
10.	I often think about whether the noises will ever go away			
11.	I am a victim of my noises			
12.	The noises have affected my concentration			

12.) **Where do you have tinnitus?**

- ❑ Both ears equally
- ❑ Both ears but not equally
- ❑ In head
- ❑ Right ear only
- ❑ Left ear only

15.) **Rate the severity of your tinnitus:**

1	2	3	4	5	6	7	8	9	10
mild									severe

16). **Estimate the pitch of your tinnitus:**

1	2	3	4	5	6	7	8	9	10
mild									severe

17.) **Is the loudness of your tinnitus steady or does it pulsate?**

- ❑ Steady
- ❑ Pulse

18.) **Overall, how would you rate the discomfort resulting from your Tinnitus?**

- ❑ None
- ❑ Mild
- ❑ Moderate
- ❑ Severe
- ❑ Very Severe

19.) **What was your education primarily?**

	Residential	Day School	Mainstreamed	Other
Elementary	❑	❑	❑	❑
Middle School/Junior High	❑	❑	❑	❑
High School	❑	❑	❑	❑

If other, please explain_____

_____

20.) **What is your preferred mode of communication <u>currently</u>**:

- ❑ American Sign Language/Signing
- ❑ Orally & Lipreading English
- ❑ Orally & Lipreading Spanish
- ❑ Home Sign
- ❑ Note Writing
- ❑ Signing Exact English
- ❑ Pidgin Sign English
- ❑ Cued Speech
- ❑ Gesture or Mime
- ❑ Other, please specify_____

21. **Please rate your fluency in ASL?**

- ❑ No knowledge
- ❑ Beginner
- ❑ Intermediate
- ❑ Fluent

22.) **If you use ASL, how old were you when you began to learn sign language?**_____

23.) **If you prefer to use ASL to communicate with people, how did you communicate with other people prior to learning sign language?**

- ❑ No communication prior to learning sign language
- ❑ Home Sign
- ❑ Gestures
- ❑ Orally/lip-reading
- ❑ Other, please specify_____

24.) **Growing up, what was the hearing status of your parents or primary caregivers?**

Mother:	❑ Hearing	Father:	❑ Hearing
_____:	❑ Deaf	_____:	❑ Deaf
	❑ Hard of hearing		❑ Hard of hearing

25.) **How did your mother (or primary female caregivers) communicate with you when you were growing up?** (Please choose all that applies)

- ❑ American Sign Language/Signing
- ❑ Orally & Lipreading English
- ❑ Orally & Lipreading Spanish
- ❑ Home Sign
- ❑ Note Writing
- ❑ Signing Exact English
- ❑ Pidgin Sign English
- ❑ Cued Speech
- ❑ Gesture or Mime
- ❑ Other, please specify_____

26.) **How did your father (or primary male caregivers) communicate with you when you were growing up?** (Please choose all that applies)

- ❑ American Sign Language/Signing
- ❑ Orally & Lipreading English
- ❑ Orally & Lipreading Spanish
- ❑ Home Sign
- ❑ Note Writing
- ❑ Signing Exact English
- ❑ Pidgin Sign English
- ❑ Cued Speech
- ❑ Gesture or Mime
- ❑ Other, please specify_____

27.) **Within Hearing culture I feel** (mark the place along the line that best describes you):

I----------I----------I----------I----------I----------I
uncomfortable comfortable

28.) **Within Deaf culture I feel** (mark the place along the line that best describes you):

I----------I----------I----------I----------I----------I
uncomfortable comfortable

29.) **How has your hearing loss impacted your life?** (Please check all that applies)

- ❑ Tension, irritation, or frustration at communication difficulties
- ❑ Feelings of inadequacy in everyday interactions
- ❑ Fear of being ridiculed, pitied, or appearing less intelligent
- ❑ Feelings of being prematurely old, handicapped, or abnormal
- ❑ Tendency to avoid social gatherings, outdoor activities, even personal interactions
- ❑ Embarrassment at having to ask for repetitions or at not understanding conversations
- ❑ Social isolation
- ❑ Physical fatigue from straining to hear
- ❑ Personal safety risks
- ❑ Other (describe):_____

_____

_____

_____