



Patient Name _____

Date _____

Please rate your level of satisfaction with the following. If your hearing aid(s) are not working, please rate your level of satisfaction prior to the malfunction. Please circle the grade.

A – Very Good

B – Good

C – Average

D – Below Average

E – Poor

Overall sound quality

Left: A B C D E

Right: A B C D E

Sound Clarity

Left: A B C D E

Right: A B C D E

The Sound of your Voice

Left: A B C D E

Right: A B C D E

Comfort of your Hearing Aids:

Left: A B C D E

Right: A B C D E

Telephone Use:

Left: A B C D E

Right: A B C D E

Performance in background noise:

Left: A B C D E

Right: A B C D E

What would you like your hearing aids to do better?

Comments: