PATIENT HEARING **CHECKLIST**

Please check all items that apply to you:

- ☐ I am younger than 18 years old.
- ☐ I hear much better in one ear than in the other ear.
- ☐ In the last 6 months, I suddenly cannot hear out of one or both ears as well as I used to.
- ☐ I have ringing, roaring, or beeping in one or both of my ears.
- ☐ I have a history of taking medication that causes hearing loss.
- ☐ I have a history of chemotherapy and/or radiation in the head and neck region.
- ☐ In the last 6 months, I have noticed active drainage from one or both of my ears.
- ☐ I have constant pain or discomfort in one or both of my ears.
- ☐ I experience dizziness.

If you check any one of the boxes above, an OTC hearing aid may not work for you. Consult with an audiologist.

Reflect on your hearing in quiet and noisy environments, and check the column that best describes you:

This Best Describes Me	Quiet Environments	Noisy Environments
☐	I have good to excellent hearing.	I have good hearing; I rarely have difficulty following/participating in a conversation.
☐	I do not have problems hearing what people say.	I may have difficulty following/participating in a conversation.
☐	I have difficulty hearing a normal voice.	I have difficulty hearing and participating in a conversation.
☐	I can hear speech if it is loud speech.	I have great difficulty hearing and participating in a conversation.
☐	I can hear loud speech if it is directly in my ear.	I have very great difficulty hearing and participating in a conversation.
☐	I have great difficulty hearing.	I cannot hear any speech.
☐	I cannot hear any speech or loud sound.	I cannot hear any speech or sound.

If you have selected an option in red text above, an OTC hearing aid may not work for you, and you should consult with an audiologist.

Please visit **ASHA.ORG/OTC-HEARING-AID-TOOLKIT** for more information.

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