DEAF OR HEARING IMPAIRED - PATIENT QUESTIONNAIRE

Please complete the following form to help us to keep your medical records up to date if you are Deaf or have a diagnosed hearing loss condition

NAME: _____ DOB: _____

Please confirm of any of the following areas apply to you **TICK if YES**

Deafness NOS	
Do you have Hearing loss	
Severe Sensorineural hearing loss	
Moderate sensorineural hearing loss	
Mild sensorineural hearing loss	
Combined visual and hearing impairment	
Hearing loss/ difficulty hearing/ hearing impaired	
Profound acquired hearing loss	
Deaf mutism NEC	
Hearing aid worn	
Uses hearing loop	
Implantation of intra-cochlear prosthesis	
Uses lip reading	
Uses sign language	
Uses British Sign Language	
Uses lip speaker	
Uses app on mobile device to support communication	
Uses text phone	
Requires contact by text relay	
Needs an Interpreter	
Uses BSL interpreter	
Interpreter is not required	
Is there anything we as a practice could do to make your experience more positive? Suggestions:	