



PATIENT SELF-ASSESSMENT OF COMMUNICATION (SAC)

Patient Name: _____ Date: _____

Instructions: Fill out this form to identify the problems you may be experiencing from hearing loss. If you wear a hearing aid(s), answer the questions according to how you communicate while wearing your hearing aid(s). Use the following descriptions to answer the statements.

(1) Never (2) Occasionally (3) About half the time (4) Frequently (5) Always

1. Do you experience communication difficulties in situations when speaking with ONE other person?
(at home, work, in social situations) 1 2 3 4 5
2. Do you experience communication difficulties while watching TV or other types of entertainment?
(movies, radio, plays) 1 2 3 4 5
3. Do you experience communication difficulties in situations when conversing with a small group of several persons?
(meetings, over dinner) 1 2 3 4 5
4. Do you experience communications difficulties when you are in an unfavorable listening environment?
(noisy party, background noise, in a car) 1 2 3 4 5
5. How often do you experience communication difficulties in situations where it's necessary to hear your best?
Situation: _____ 1 2 3 4 5
6. Do you experience difficulty in hearing soft, medium and loud environmental sounds appropriately?
(telephone, doorbell, horns, alarms) 1 2 3 4 5
7. Do you feel that any difficulty with hearing negatively affects or hampers your personal life or social life?
 1 2 3 4 5
8. Do you feel that any problem or difficulty with hearing worries, annoys or upsets you?
 1 2 3 4 5
9. Do you or others seem to be concerned or annoyed that you have a hearing problem?
 1 2 3 4 5
10. How often does hearing loss negatively affect your enjoyment of life?
 1 2 3 4 5
11. If you use a hearing aid(s): On an average day, how many hours do you wear your hearing aid(s)? _____ Hours

If applicable, how satisfied are you with your current hearing aid(s)?

1. Not satisfied 2. Slightly satisfied 3. Moderately satisfied 4. Mostly satisfied 5. Very satisfied