

Do I Need a Hearing Test? Signs You Shouldn't Ignore

By ProRehab Audiology | June 2026

Hearing loss is one of the most prevalent — and most underestimated — chronic health conditions in the world. According to the World Health Organization (2021), over 1.5 billion people globally live with some degree of hearing loss, a figure projected to rise to 2.5 billion by 2050. In the United Kingdom alone, Action on Hearing Loss estimates that approximately 12 million adults have clinically significant hearing impairment, yet the average person waits a staggering **ten years** between first noticing a change in their hearing and seeking professional help (Davis et al., 2016).

That delay has consequences — not merely for communication, but for cognition, mental health, social participation, and long-term quality of life. The purpose of this article is simple: to help you recognise the signs that your hearing deserves professional attention, and to explain why acting early matters far more than most people realise.

Why We Dismiss the Signs

Hearing loss is rarely dramatic in its onset. Unlike a broken bone or a sudden illness, it tends to arrive gradually — so gradually, in fact, that the brain compensates in real time, filling in gaps using context, lip reading, and cognitive effort (Pichora-Fuller et al., 2016). This neurological workaround is remarkably effective in the short term, which is precisely why so many people are genuinely surprised when an audiologist tells them their hearing has deteriorated significantly.

The result is a phenomenon clinicians call **hearing loss denial** — not deliberate avoidance, but an honest failure to recognise a change that has occurred too slowly to trigger alarm (Hetu, 1996). Understanding this is essential. The signs listed below are not always obvious to the person experiencing them; they are often noticed first by partners, family members, or colleagues.

The Signs You Shouldn't Ignore

1. You Frequently Ask People to Repeat Themselves

This is the single most reported early symptom of hearing loss. If you find yourself asking “sorry, could you say that again?” multiple times in a conversation — particularly in quiet environments where background noise cannot be blamed — your auditory system may be struggling to process speech clearly (Yueh et al., 2003).

The critical distinction is between *mishearing* and *not hearing*. People with early high-frequency hearing loss often hear that someone is speaking but cannot distinguish the consonants that give speech its intelligibility. Words become muddled; “fish” sounds like “fist,” “thin” like “chin.”

2. You Struggle in Background Noise

Difficulty hearing in noisy environments — restaurants, social gatherings, open-plan offices — is one of the most diagnostically significant early indicators of sensorineural hearing loss. It has a specific name: **speech-in-noise difficulty**, and it often precedes measurable threshold shifts on a standard audiogram (Füllgrabe et al., 2015).

Importantly, struggling in noise is not simply a normal consequence of ageing or a noisy room. It reflects the ear’s diminishing ability to separate signal from background — a function that depends on the integrity of the outer hair cells of the cochlea. When these cells are damaged, the cocktail party becomes an indecipherable blur.

3. You’ve Turned the Television Volume Up (and Others Have Noticed)

A frequently raised television volume is one of the most reliable proxy measures of unaddressed hearing loss in adults over 50 — and one of the most common reasons family members encourage a relative to seek assessment. Research by Gopinath et al. (2012) found that self-reported television difficulties were significantly associated with audiometrically confirmed hearing loss across a large population-based cohort.

If family members comment on the volume, or if you find yourself turning on subtitles not for preference but for necessity, this is worth taking seriously.

4. You Find Telephone Conversations Particularly Difficult

Phone calls strip away the visual cues — lip movement, facial expression, gesture — that most people use unconsciously to supplement their hearing. For someone with early hearing loss, this is often where the difficulty becomes most apparent. Mobile phone audio, with its compressed frequency range, can be especially challenging for those with high-frequency loss.

If you avoid phone calls, feel anxious about them, or routinely mishear the person on the other end, these are meaningful clinical signals.

5. You Experience Tinnitus

Tinnitus — the perception of sound (ringing, buzzing, hissing, or clicking) in the absence of an external source — affects approximately 13% of UK adults (Hoare et al., 2014). While tinnitus can occur with normal audiometric thresholds, it is frequently associated with underlying cochlear damage and often co-exists with hearing loss, even when that loss has not yet become functionally apparent.

The British Tinnitus Association and NICE both recommend that individuals with persistent tinnitus lasting longer than five minutes at a time, occurring more than once a week, seek audiological assessment (NICE NG155, 2020). Tinnitus that is unilateral (one-sided), pulsatile, or accompanied by dizziness warrants urgent referral to rule out retrocochlear pathology.

6. You Feel Mentally Exhausted After Conversations

“Listening fatigue” is a well-documented consequence of hearing loss that is rarely discussed in public health messaging. When the auditory system is working at reduced capacity, the brain compensates by devoting disproportionate cognitive resources to speech processing — resources that would otherwise be available for memory encoding, attention, and executive function (Pichora-Fuller et al., 2016).

The result is that conversations — particularly in groups or noisy settings — leave people with unaddressed hearing loss feeling disproportionately tired. If you find social interactions draining in a way that feels qualitatively different from simple introversion, it may be worth considering whether hearing is a contributing factor.

7. You’ve Withdrawn from Social Situations

This is perhaps the most consequential sign of all — and the one most closely linked to longer-term health outcomes. A landmark longitudinal study by Lin et al. (2011), published in *Archives of Neurology*, found that mild hearing loss was associated with a two-fold increased risk of dementia, with the risk rising incrementally with severity of loss. While the causal mechanisms remain under investigation, social withdrawal, cognitive underload, and reduced auditory stimulation of neural pathways are all implicated.

If you find yourself avoiding gatherings, restaurants, or group settings because of the effort involved — or declining social invitations that you would previously have welcomed — this pattern deserves clinical attention.

What Does a Hearing Test Actually Involve?

A comprehensive audiological assessment is painless, non-invasive, and typically takes 45 to 60 minutes. It includes:

- **Otoscopy** — visual examination of the ear canal and tympanic membrane to exclude wax, infection, or structural abnormality
- **Pure tone audiometry** — the standard “raise your hand when you hear a beep” test, establishing hearing thresholds across a range of frequencies
- **Speech audiometry** — testing the ability to identify words and sentences at different volumes, giving a functional picture beyond pure thresholds
- **Tympanometry** — a pressure test assessing middle ear function and eardrum mobility

Results are presented on an audiogram, a graphical representation of hearing across frequencies. A qualified audiologist will interpret this in the context of your history, symptoms, and lifestyle to determine whether intervention — whether that is earwax removal, amplification, or onward referral — is indicated.

The Cost of Waiting

The evidence is unambiguous: earlier intervention produces better outcomes. Hearing aids fitted before hearing loss becomes severe are associated with greater benefit, faster adaptation, and significantly improved quality of life compared to those fitted late (Chisolm et al., 2007). Beyond amplification, early identification opens the door to auditory rehabilitation, communication strategies, and — where tinnitus is present — tinnitus management programmes that are far more effective when introduced early.

Hearing is not a luxury. It underpins communication, cognition, safety, and connection. If you recognise any of the signs described above — in yourself or in someone you care about — a hearing assessment is not an overreaction. It is a straightforward, evidence-based step toward protecting one of your most valuable senses.

References

Action on Hearing Loss. (2015). *Hearing Matters*. Action on Hearing Loss UK.

Chisolm, T.H., Johnson, C.E., Danhauer, J.L., Portz, L.J., Abrams, H.B., Lesner, S., ... & Newman, C.W. (2007). A systematic review of health-related quality of life and hearing aids. *Journal of the American Academy of Audiology*, 18(2), 151–183.

Davis, A., McMahon, C.M., Pichora-Fuller, K.M., Russ, S., Lin, F., Olusanya, B.O., ... &

Tremblay, K.L. (2016). Aging and hearing health: the life-course approach. *Gerontologist*, 56(Suppl 2), S256–S267.

Füllgrabe, C., Moore, B.C., & Stone, M.A. (2015). Age-group differences in speech identification despite matched audiometrically normal hearing: contributions from auditory temporal processing and cognition. *Frontiers in Aging Neuroscience*, 6, 347.

Gopinath, B., Schneider, J., Hickson, L., McMahon, C.M., Burlutsky, G., Leeder, S.R., & Mitchell, P. (2012). Hearing handicap, rather than measured hearing impairment, predicts poorer quality of life over 10 years in older adults. *Maturitas*, 72(2), 146–151.

Hetu, R. (1996). The stigma attached to hearing impairment. *Scandinavian Audiology*, 25(Suppl 43), 12–24.

Hoare, D.J., Edmondson-Jones, M., Sereda, M., Akeroyd, M.A., & Hall, D. (2014). Amplification with hearing aids for patients with tinnitus and co-existing hearing loss. *Cochrane Database of Systematic Reviews*, (1), CD010151.

Lin, F.R., Metter, E.J., O'Brien, R.J., Resnick, S.M., Zonderman, A.B., & Ferrucci, L. (2011). Hearing loss and incident dementia. *Archives of Neurology*, 68(2), 214–220.

NICE. (2020). *Tinnitus: assessment and management* (NG155). National Institute for Health and Care Excellence. <https://www.nice.org.uk/guidance/ng155>

Pichora-Fuller, M.K., Kramer, S.E., Eckert, M.A., Edwards, B., Hornsby, B.W., Humes, L.E., ... & Wingfield, A. (2016). Hearing impairment and cognitive energy: the framework for understanding effortful listening (FUEL). *Ear and Hearing*, 37(Suppl 1), 5S–27S.

World Health Organization. (2021). *World Report on Hearing*. WHO Press.

Yueh, B., Shapiro, N., MacLean, C.H., & Shekelle, P.G. (2003). Screening and management of adult hearing loss in primary care. *JAMA*, 289(15), 1976–1985.