Hearing Assessment

Client's *(Surname)*	*(First Name)*	*(Initial)*	Date of Birth *(Year / Month / Day)* 2015/10/22
Address *Street*		*City/Town*	*State / Province*
Zip / Postal Code	Telephone Number	Date of Service *(Year / Month / Day)*	

Puretone Audiometry

Speech Audiometry

Discrimination Loss

	SAT	SRT	Mask	MCL	UCL	%	Stimulus	Mask	%	Stimulus	Noise
R											
L											
Binaural											
SF											
SF-A											
SF-A2											

Speech Materials

SRT/SDT
DISCRIM

MASK

MLV ☐ REC ☐

EST. Accuracy: _____

Insert Headphones ☐ Yes ☒ No

Key	Air		Bone		No Response
	Unmasked	Masked	Unmasked	Masked	
Right	○	△	<	⊏	↙
Left	×	□	>	⊐	↘

Middle Ear Function

Tympanograms
Pressure mm H2 O

	Right	Left
Type		
ME Pressure		
Compliance		
Volume		

Acoustic Reflexes

	Right		Left	
	Contra	IPSI	IPSI	Contra
	Tone R Probe L	Tone R Probe R	Tone L Probe L	Tone L Probe R
500 Hz				
1000 Hz				
2000 Hz				
4000 Hz				

Reflex Decay:

	RIGHT		LEFT	
500 Hz	☐ Negative	☐ Positive	☐ Negative	☐ Positive
1000Hz	☐ Negative	☐ Positive	☐ Negative	☐ Positive

Abbreviations

CNT: Did/Could Not Test
A: Aided
SAT: Speech Recaption/Awareness Threshold
SF: Sound Field
MCL: Most Comfortable Loudness Level
UCL: Uncomfortable loudness Level
MLV: Monitored Live Voice
HL: Hearing Level
NBN: Narrow Band Noise
FM: Frequency Modulation
WNL: Within Normal Limits
CNM: Could Not Mask
NR: No Response
VIB: Vibrotactile

Client's Name: *(Surname)* *(Given Name)* *(Initial)*

Background Information

	Right (R)	Left (L)
Hearing Difficulty	☐	☐
Tinnitus Intermittent	☐	☐
Tinnitus Constant	☐	☐
Pressure / Fullness	☐	☐
Ear Infections	☐	☐
Surgery	☐	☐
Head Trauma	☐	☐
Ear Pain	☐	☐

Current Hearing Aid ☐ Right ☐ Left

Style _____

Make _____

Model _____

Serial Number _____

Date Purchased _____

☐ Vertigo _____
☐ E.N.T _____
☐ Infectious Diseases _____
☐ Congenital Difficulties _____
☐ Noise Exposure _____
☐ Ototoxic Medications _____
☐ Family History of Hearing Loss _____

Comments

Results

Degree of Hearing Loss	R	L
Normal	☐	☐
Minimal	☐	☐
Mild	☐	☐
Moderate	☐	☐
Moderate-Severe	☐	☐
Severe	☐	☐
Profound	☐	☐

Type of Hearing Loss	R	L
High Frequency	☐	☐
Low Frequency	☐	☐
Conductive	☐	☐
Sensorineural	☐	☐
Mixed	☐	☐

Middle Ear Function	R	L
Normal Tympanogram	☐	☐
Negative Middle Ear Pressure	☐	☐
Flat/Rounded Tympanogram	☐	☐
High Compliance	☐	☐
Low Compliance	☐	☐
Absent/Elevated Acoustic Reflexes	☐	☐
Large Physical Volume	☐	☐

ICD Codes & Descriptions

Recommendations

☐ Family Physician Referral _____
☐ Otologic (E.N.T.) Referral _____
☐ Audiologic Reassessment After Medical Treatment _____
☐ Reassessment: _____
☐ Specialized Testing: _____
☐ Other: _____

☐ Hearing Conservation Measures
☐ Hearing Aid Repair
☐ Hearing Aid Trial
☐ Auditory Brain Response (ABR)

Summary/Comments

Assessment Completed By:

Print Name: **Signature:**