

Client's (Surname)	(First Name)	(Initial)	Date of Birth	(Year / Month / Day)
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 Reception/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	<input type="checkbox"/>	<input type="checkbox"/>
Tinnitus Intermittent	<input type="checkbox"/>	<input type="checkbox"/>
Tinnitus Constant	<input type="checkbox"/>	<input type="checkbox"/>
Pressure / Fullness	<input type="checkbox"/>	<input type="checkbox"/>
Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>
Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Head Trauma	<input type="checkbox"/>	<input type="checkbox"/>
Ear Pain	<input type="checkbox"/>	<input type="checkbox"/>

Current Hearing Aid Right Left

Style _____

Make _____

Model _____

Serial Number _____

Date Purchased _____

<input type="checkbox"/>	Vertigo _____
<input type="checkbox"/>	E.N.T. _____
<input type="checkbox"/>	Infectious Diseases _____
<input type="checkbox"/>	Congenital Difficulties _____
<input type="checkbox"/>	Noise Exposure _____
<input type="checkbox"/>	Ototoxic Medications _____
<input type="checkbox"/>	Family History of Hearing Loss _____

Comments

Results

Degree of Hearing Loss

	R	L
Normal	<input type="checkbox"/>	<input type="checkbox"/>
Minimal	<input type="checkbox"/>	<input type="checkbox"/>
Mild	<input type="checkbox"/>	<input type="checkbox"/>
Moderate	<input type="checkbox"/>	<input type="checkbox"/>
Moderate-Severe	<input type="checkbox"/>	<input type="checkbox"/>
Severe	<input type="checkbox"/>	<input type="checkbox"/>
Profound	<input type="checkbox"/>	<input type="checkbox"/>

Type of Hearing Loss

High Frequency
 Low Frequency
 Conductive
 Sensorineural
 Mixed

	R	L
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

Middle Ear Function

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

	R	L
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

ICD Codes & Descriptions

Recommendations

<input type="checkbox"/>	Family Physician Referral _____
<input type="checkbox"/>	Otologic (E.N.T.) Referral _____
<input type="checkbox"/>	Audiologic Reassessment After Medical Treatment _____
<input type="checkbox"/>	Reassessment: _____
<input type="checkbox"/>	Specialized Testing: _____
<input type="checkbox"/>	Other: _____

<input type="checkbox"/>	Hearing Conservation Measures
<input type="checkbox"/>	Hearing Aid Repair
<input type="checkbox"/>	Hearing Aid Trial
<input type="checkbox"/>	Auditory Brain Response (ABR)

Summary/Comments

Assessment Completed By:

Print Name:

Signature: