

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	×	□	>	□	↘

Tympanograms		Middle Ear Function			
Pressure mm H2 O		Acoustic Reflexes			
		Right		Left	
Type		Contra	IPSI	IPSI	Contra
ME Pressure		Tone R Probe L	Tone R Probe R	Tone L Probe L	Tone L Probe R
Compliance					
Volume					

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**

	<b>R</b>	<b>L</b>
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

	<b>R</b>	<b>L</b>
<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"/>
<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

	<b>R</b>	<b>L</b>
<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"/>
<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: