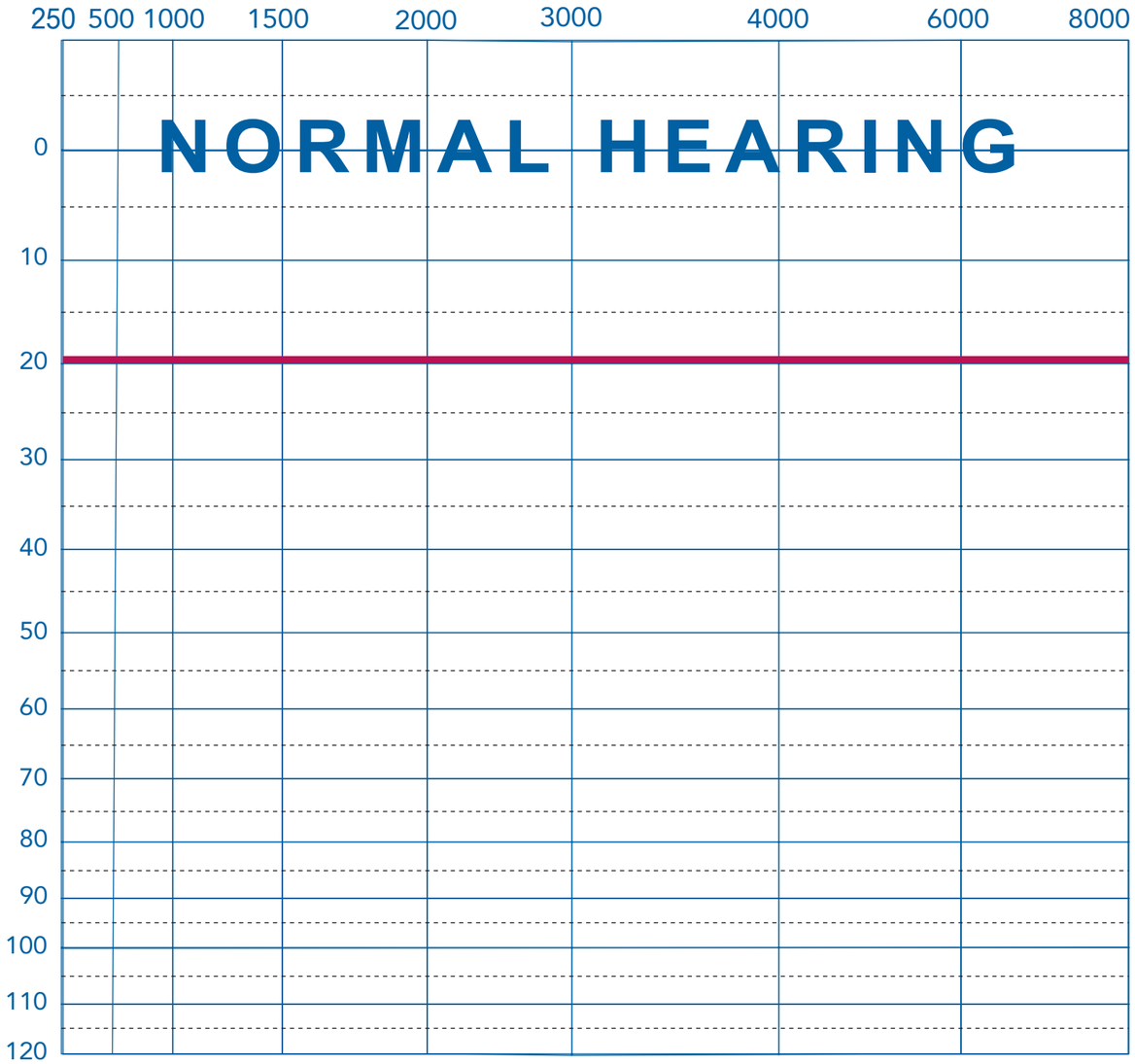
AUDIOGRAM

Date: _____



SRT: ____ MCL: ____ UCL: ____ Discrim %: ____

RIGHT EAR

SRT: ____ MCL: ____ UCL: ____ Discrim %: ____

LEFT EAR

BI DISC%: ____

CASE HISTORY: _____

Previous Instrument: _____ with vent size _____

Previous Occlusion: _____

Special Consideration: _____

HEARING PROFESSIONAL:

Name: _____

Title: _____

License Number: _____

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EarCare

HEARING HEALTH REPORT

INQUIRY, OBSERVATION, AND HEARING TEST RESULTS

PATIENT'S NAME _____ TODAY'S DATE _____

STREET _____

CITY _____ STATE _____ ZIPCODE _____

PHONE _____ DATE OF BIRTH _____

CELL PHONE _____ OCCUPATION _____

PAST ☐ PRESENT ☐

EMAIL _____

ALTERNATE ADDRESS (WINTER/SUMMER/SECOND HOME) STREET

_____

CITY _____ STATE _____ ZIPCODE _____

MARITAL STATUS SINGLE ☐ MARRIED ☐ WIDOWED ☐

NAME OF SPOUSE _____

HOW DID YOU HEAR ABOUT US

MAIL ☐ PHONE ☐ NEWSPAPER ☐ YELLOW PAGES ☐ TELEVISION ☐ WEB ☐ PHYSICIAN ☐

☐ REFERRAL: _____

☐ OTHER: _____

HEARING CHECKLIST

Who encouraged you to come to see a hearing professional today ?_____

NO	YES	
☐	☐	1. You can hear, but have difficulty understanding.
☐	☐	2. You have difficulty understanding children or those with high-pitched voices.
☐	☐	3. You find yourself complaining that some people mumble or slur their words.
☐	☐	4. You have difficulty understanding what's being said unless you are facing the speaker.
☐	☐	5. You are continually asking certain people to repeat words or phrases, though they feel they are speaking loud enough.
☐	☐	6. You prefer the TV or radio louder than others do.
☐	☐	7. You have difficulty understanding conversation within a group of people.
☐	☐	8. You avoid group meetings, social occasions, public facilities or family gatherings where listening may be difficult.
☐	☐	9. You have trouble hearing at the movies, concert halls, houses of worship or other public gatherings —especially where sound sources are at a distance.
☐	☐	10. You experience ringing, hissing, buzzing, whistling, roaring or even chirping noises in your ears.
☐	☐	11. Do you have concerns about balance,falling or your mobility.
☐	☐	12. Have you had any concerns about your memory lately.
☐	☐	13. Has your primary care physician suggested that you increase your level of physical activity.
☐	☐	14. If a hearing loss is discovered are you ready for help.

HEARING AID HISTORY

Have you ever worn or had any experience with a hearing aid? ☐ Yes ☐ No

Which ear? ☐ LEFT ☐ RIGHT ☐ BOTH If so, when did you get your first hearing aid? _____

What kind did you, or do you wear? Make: _____ Style: _____

Do you have any difficulty hearing with, or using this hearing aid? ☐ Yes ☐ No

Describe:_____

PATIENT'S HEARING HISTORY

Family member with memory loss, dementia or Alzheimer's Disease:_____

Family members with hearing loss:_____

Onset of hearing loss? Approx. date: _____

Suspected cause:_____

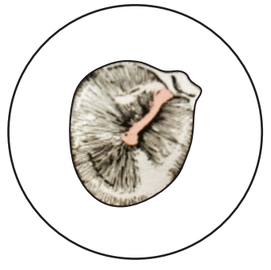
INQUIRY

NO	YES	
☐	☐	• Acute or chronic dizziness?
	LEFT RIGHT	
☐	☐ ☐	1. Will this be your first hearing test?
☐	☐ ☐	2. Does hearing fluctuate? Describe:_____
☐	☐	3. Tinnitus/Ringing in ears? Describe:_____
☐	☐ ☐	4. Deformity of the ear ?Describe:_____
☐	☐ ☐	5. Noise exposure history? Describe:_____
☐	☐ ☐	6. Pain or discomfort in the ear? Describe:_____
☐	☐ ☐	7. History of sudden or rapidly progressive hearing loss within the previous 90 days?
☐	☐ ☐	8. Unilateral hearing loss of sudden or recent onset within the previous 90 days?
☐	☐ ☐	9. History of active drainage from the ear within the previous 90 days?
☐	☐ ☐	10. Previous medical attention for ears Describe:_____
☐	☐ ☐	11. Previous ear infections? Describe:_____
☐	☐ ☐	12. Ears feel full or blocked? Describe:_____

OTOSCOPY / CERUMEN MANAGEMENT

RIGHT EAR

CLARITY:
Good ☐
Fair ☐
Poor ☐



DISCHARGE:
Yes ☐ No ☐

ODOR:
Yes ☐
No ☐

CERUMEN: Light ☐ Moderate ☐ Heavy ☐

CERUMEN MANAGEMENT: Yes ☐ No ☐

LEFT EAR

CLARITY:
Good ☐
Fair ☐
Poor ☐

DISCHARGE:
Yes ☐ No ☐

ODOR:
Yes ☐
No ☐

CERUMEN: Light ☐ Moderate ☐ Heavy ☐

CERUMEN MANAGEMENT: Yes ☐ No ☐