Hearing Screening (Adults)

Name ________________________________ **Birth Date** _________________

Age _______

Screening Unit/Examiner ________________________________ **Calibration Date** __________

CASE HISTORY—CIRCLE APPROPRIATE ANSWERS					
Do you think you have a hearing loss?				Yes	No
Have hearing aid(s) ever been recommended for you?				Yes	No
Is your hearing better in one ear?				Yes	No
If yes, which is the better ear?	Right	Left			
Have you ever had a sudden or rapid progression of hearing loss?					
Do you have ringing or noises in your ears?				Yes	No
If yes,	Right	Left	Both		
Do you consider dizziness to be a problem for you?				Yes	No
Have you had recent drainage from your ear(s)?				Yes	No
If yes,	Right	Left			
Do you have pain or discomfort in your ear(s)?				Yes	No
If yes,	Right	Left			
Have you received medical consultation for any of the above conditions?				Yes	No
PASS **REFER**					

VISUAL/OTOSCOPIC INSPECTION

PASS **REFER** **Right** **Left**

Referral for cerumen management __________ **Referral for medical evaluation** __________

PURE-TONE SCREEN (25 DB HL) (R = RESPONSE, NR = NO RESPONSE)

Frequency	**1000**	**2000**	**4000 Hz**
Right Ear	____	____	_______
Left Ear	____	____	_______

PASS **REFER**

HEARING-DISABILITY INDEX

Score: HHIE-S______________ SAC_____________ Other______________Score____________

PASS **REFER**

Discharge _____ Medical Examination _____ Counsel
_____ Cerumen _____ Management

Comments ____

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To locate an ASHA certified Audiologist, go to http://www.asha.org/profind/.