American Speech-Language-Hearing Association

Hearing Screening (Adults)

Name _____ **Birth Date**_____

Age _____ **Gender: M**_____ **F**_____

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/.