Lakes Area Hearing Solutions

Date____________________

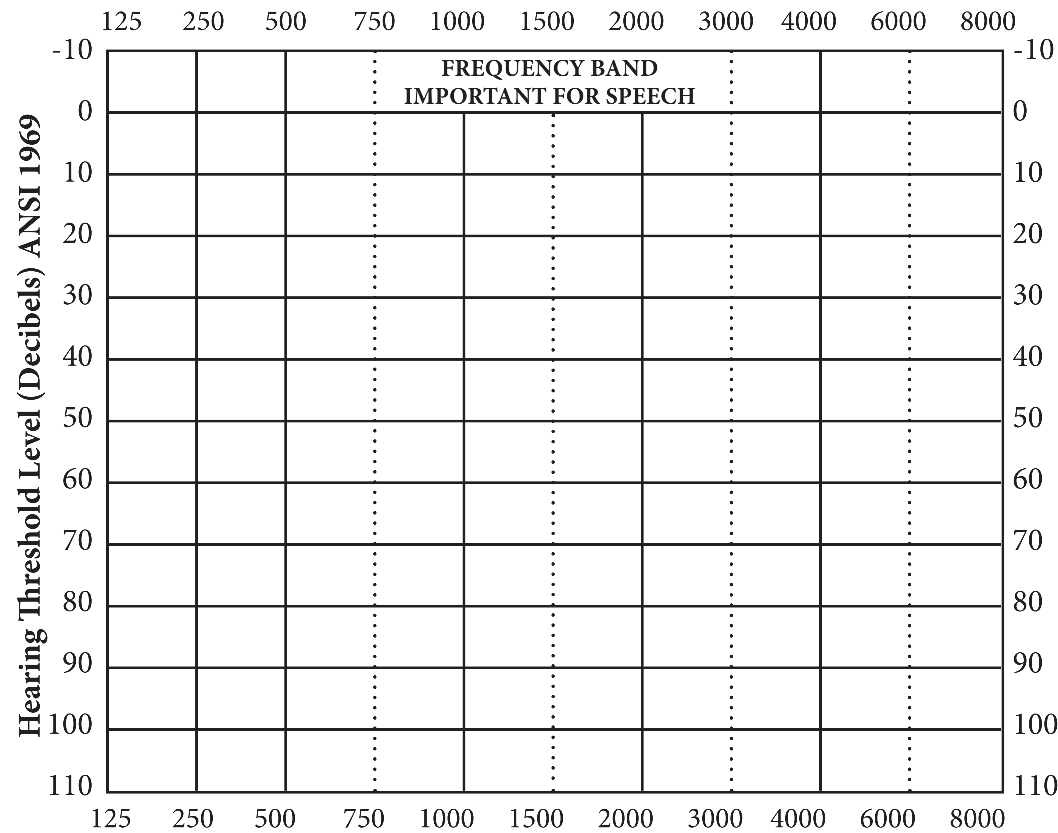
Lic #____________________

Specialist____________________

Pt Name____________________

SOUNDS OF SPEECH

LOUD SOUNDS	SOFT SOUNDS
A • E • I • O • U	CH • SH • S • F • TH



Normal

Borderline

Mild

Moderate

Severe

Profound

Average Pure Tone	
LEFT	RIGHT

Audiogram Key	Left	Right
AC Unmasked	X	O
AC Masked	□	△
BC Unmasked	>	<
BC Masked	]	[
BC Forehead	⌜	⌟
Both		
BC Forehead Unmasked	V	
Sound Field	S	
No Response		

Spondees - Track 3

1. Mousetrap
2. Daybreak
3. Doormat
4. Schoolboy
5. Inkwell
6. Oatmeal
7. Greyhound
8. Whitewash
9. Farewell
10. Padlock
11. Stairway
12. Toothbrush
13. Pancake
14. Grandson
15. Headlight
16. Horseshoe
17. Duckpond
18. Hothouse
19. Workshop
20. Baseball
21. Hotdog
22. Iceberg
23. Airplane
24. Armchair
25. Playground
26. Drawbridge
27. Woodwork
28. Mushroom
29. Railroad
30. Sidewalk
31. Northwest
32. Sunset
33. Eardrum
34. Birthday
35. Cowboy
36. Hardware

PBs - Track 17

1. ____ Pass
2. ____ Doll
3. ____ Back
4. ____ Red
5. ____ Wash
6. ____ Sour
7. ____ Bone
8. ____ Get
9. ____ Wheat
10. ____ Thumb
11. ____ Sail
12. ____ Yearn
13. ____ Wife
14. ____ Such
15. ____ Neat
16. ____ Peg
17. ____ Mob
18. ____ Gas
19. ____ Check
20. ____ Join
21. ____ Lease
22. ____ Long
23. ____ Chain
24. ____ Kill
25. ____ Hole

Left ____ Right ____ Both ____

Speech Audiometry

Calibration

❑ SPL ❑ HTL ❑ TAPE ❑ MLV ❑ CD

	LEFT	RIGHT	BINAURAL
SRT	dB	dB	
MCL	dB	dB	
UCL	dB	dB	
Discrimination	%	%	%
Discrimination Presentation Level	dB	dB	dB

PBs - Track 16

1. ____ Base
2. ____ Mess
3. ____ Cause
4. ____ Mop
5. ____ Good
6. ____ Luck
7. ____ Walk
8. ____ Youth
9. ____ Pain
10. ____ Date
11. ____ Pearl
12. ____ Search
13. ____ Ditch
14. ____ Talk
15. ____ Ring
16. ____ Germ
17. ____ Life
18. ____ Team
19. ____ Lid
20. ____ Pole
21. ____ Road
22. ____ Shell
23. ____ Late
24. ____ Cheek
25. ____ Beg
26. ____ Gun
27. ____ Jug
28. ____ Sheep
29. ____ Five
30. ____ Rush
31. ____ Rat
32. ____ Void
33. ____ Wire
34. ____ Half
35. ____ Note
36. ____ When
37. ____ Name
38. ____ Thin
39. ____ Tell
40. ____ Bar
41. ____ Mouse
42. ____ Hire
43. ____ Cab
44. ____ Hit
45. ____ Chat
46. ____ Phone
47. ____ Soup
48. ____ Dodge
49. ____ Seize
50. ____ Cool

Lakes Area Hearing Solutions

Our concern is your hearing and to better help you we ask that you fill out this questionnaire to describe in what ways your hearing affects you. This information is kept confidential and is made a part of your file. Thank you for placing your trust in us for all your hearing needs. Please complete the front and back side and return to the front desk.

Date:______________________________

Name:____ Date of Birth:__________

Address:____ (CITY) (ST) (ZIP)

Telephone:______________________________ Email:______________________________

How did you hear about us: ❑ Flyer ❑ TV ❑ Internet ❑ Friends ❑ Other ____________________

Spouse / Partner or Observing Party:______________________________ Telephone:__________________

MEDICAL/AUDIOLOGIC HISTORY

YES	NO	
❑	❑	Will this be the first time you've had a hearing test? If no, what was the date of your last test?_______________
❑	❑	Do you have noises or ringing in your ears?
❑	❑	Do you have a family history of hearing loss?
❑	❑	Have you been exposed to a lot of noise in your life?
❑	❑	Do you have difficulty hearing when someone speaks in a whisper?
❑	❑	Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?
❑	❑	Does a hearing problem cause you to not understand in church?
❑	❑	Does a hearing problem cause you difficulty when listening to TV or radio?
❑	❑	Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?
❑	❑	Do you have difficulty hearing women or children?
❑	❑	Do you wear hearing aids? If yes, approximately how many hours a day do you wear them?__________________
❑	❑	Do you have problems with your hearing aids? If yes, explain:__________________

- In which ear do you hear better? Please circle: LEFT RIGHT UNKNOWN
- What do you believe caused your hearing problem?____
- What have others noticed about your understanding/communication ability?____________________
- Why have you decided to have your hearing tested at this time?
  - ❑ I feel my hearing is poor and may need to be aided.
  - ❑ Family/friends have suggested I have my hearing checked.
  - ❑ Other reason/explain:____

HEARING HEALTH CARE PROFESSIONAL AUTHORIZATION

By signing this form, I understand that I am giving **Springfield Hearing Center** authorization to use or disclose my hearing health information for the purpose of addressing my health care needs. I understand that at no time will my information be used for purposes beyond that end.

RECIPIENT: My health information may be disclosed by **Springfield Hearing Center** to the following person(s) or class of persons:

____Physician(s):________________________________

____Family (Specify):________________________________

____ Friend (Specify):________________________________

____Healthcare Organization (Specify):________________________________

RIGHT TO REVOKE: I understand that I may restrict the individuals or organizations to which my healthcare information is released. Further, I understand that I may revoke my authorization at any time; however, my revocation must be in writing, mailed to **Springfield Hearing Center** at the office address listed below, and **Springfield Hearing Center** must only comply with such revocation to the extent it is consistent with its Notice of Privacy Practices.

REFUSAL: I have the right to refuse to give **Springfield Hearing Center** this authorization. If I do not give the authorization, **Springfield Hearing Center** may refuse to treat me if I do not sign the authorization.

INSPECT/COPY: I may inspect or copy the information that **Springfield Hearing Center** may send at any time.

TERMS: This notice is effective as of the date set forth below and will remain in effect until: patient or clinic terminates.

I hereby acknowledge that I have received a copy of this authorization. I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signing below, I hereby knowingly and voluntarily authorize **Springfield Hearing Center** to use or disclose my health information in the manner described above.

MEDICAL EVALUATION REQUIREMENTS: Every patient should be encouraged to seek counsel from their physician prior to hearing aid fitting. If the patient is over 18 years old and does not exhibit one of the eight red flags, they have the option of signing a medical waiver. For persons under the age of 18 years old, a medical clearance from a physician is required prior to fitting. Children should be encouraged to seek help form an audiologist "...since hearing loss may cause problems in language development and the educational and social growth of the child" 21 CFR801.420

I have been advised by **Springfield Hearing Center** that the Food and Drug Administration has determined that my best interest would be served if I had a medical evaluation by a licensed physician (preferably one who specializes in diseases of the ear) before purchasing hearing aids. I do not require a medical evaluation before receiving a hearing test or purchasing hearing aids at this time.

________________________________ Signature of Patient (or Personal Representative)

________________________________ Effective Date

________________________________ Print Patient Name

________________________________ Personal Representative Authority

________________________________ Print Name of Personal Representative (if applicable)

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: ________________________________

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NOTES: ________________________________

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THIS SECTION IF FOR OFFICE USE ONLY
FDA QUESTIONS

YES	NO	
☐	☐	Visible Congenital or traumatic deformity of the ear.
☐	☐	History of active drainage from the ear within the previous 90 days.
☐	☐	History of sudden or rapidly progressing hearing loss within the previous 90 days.
☐	☐	Acute or chronic dizziness.
☐	☐	Unilateral hearing loss of sudden or recent onset within the previous 90 days.
☐	☐	Audiometric air-bone gap equal to or greater than 15 decibels at 500 Hertz (Hz), 1,000 Hz and 2,000 Hz.
☐	☐	Visible evidence of significant cerumen accumulation of a foreign body in the ear canal.
☐	☐	Pain or discomfort in the ear.