PEE DEE SPEECH & HEARING CENTER

HEARING HEALTH REPORT

Today's Date _____

Patient's Name _____ Date of Birth _____ Gender Male Female

Address _____ City _____ State _____ Zip _____

Preferred Phone # _____ ☐ OK to Text work cell home Secondary Phone # _____ work cell home

Email _____ Occupation _____ ☐ Past ☐ Present

Marital Status ☐ Single ☐ Married ☐ Widowed Name of Spouse _____

Name of Observing Party _____ Relationship _____

Name of Family Physician _____

Permission to release a copy of test information to family physician ☐ Yes ☐ No

Please specify your ethnicity:

Caucasian African-American Latino or Hispanic Asian Native American Native Hawaiian or Pacific Islander Other/Unknown Prefer not to say

Insurer Name _____ Insurer Phone _____

Insurance ID No. _____ Insurance Group No. _____

How did you hear about us? ☐ Mail ☐ Newspaper ☐ Google ☐ Physician ☐ Insurance ☐ Friend
☐ Other _____

Hearing Health History

Do you have any allergies? ☐ Yes ☐ No If yes, please list _____

Are you an insulin-dependent diabetic? ☐ Yes ☐ No

Are you currently taking any medications? ☐ Yes ☐ No If yes, please list _____

Do you have arthritis? ☐ Yes ☐ No

Do you have any ringing in your ears? ☐ Yes ☐ No If yes, which ear? _____

Have you been exposed to loud sounds in your life? ☐ Yes ☐ No If yes, please describe? _____

Have you previously had a hearing test? ☐ Yes ☐ No If yes, by whom? _____ Date _____

Have you received any medical or surgical treatment for a hearing loss? ☐ Yes ☐ No

If yes, when? _____ Physician/ENT _____ Phone _____

Additional Information about treatment: _____

Patient HIPAA Consent, Insurance and Payment

I understand that I have certain rights to privacy regarding my protected health information according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize the clinic to use and disclose my protected health information for the purpose of:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment):
- Obtaining payment from insurance or third-party benefit plans:
- The day-to-day healthcare operations of the clinic such as quality assessments and provider certifications.

Insurance and Payment

I authorize the clinic to provide medical treatment and file my insurance and third-party benefit claims. I authorize payments of medical benefits to be paid directly to the clinic. I understand that I am financially responsible to the organization of any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of them are denied payment.

**** I accept FULL responsibility for ALL charges in the event that I have NO Insurance or third party benefits, or they elect NOT to cover Payment ****

Do we have permission to contact your companion/caregiver (if applicable)? ☐ Yes ☐ No Please list contact info below:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Patient Signature or Legal Custodian _____ Date _____

Communication Assessment

Listening Environments	How well do you currently hear in this listening environment?			How frequently are you in this listening environment?		
	WELL	FAIR	POOR	OFTEN	SOMETIMES	RARELY
One on One Conversations	◯	◯	◯	◯	◯	◯
Quiet Room (1-2 People)	◯	◯	◯	◯	◯	◯
Small Groups (3-6 People)	◯	◯	◯	◯	◯	◯
Large Social Gatherings	◯	◯	◯	◯	◯	◯
Watching TV	◯	◯	◯	◯	◯	◯
During Religious Services	◯	◯	◯	◯	◯	◯
Meetings	◯	◯	◯	◯	◯	◯
In the Car	◯	◯	◯	◯	◯	◯
Outdoors	◯	◯	◯	◯	◯	◯
On the Telephone	◯	◯	◯	◯	◯	◯

Amplification History

Are you a current hearing aid wearer? ☐ Yes ☐ No Type _____ Ear Fitted: ☐ Both ☐ Left ☐ Right

How long have you worn hearing aids? _____

If yes, and you could improve something about your current hearing instruments, what would that be? _____

_____

What type of cell phone do you have? _____

FOR OFFICE USE ONLY

FDA Questions

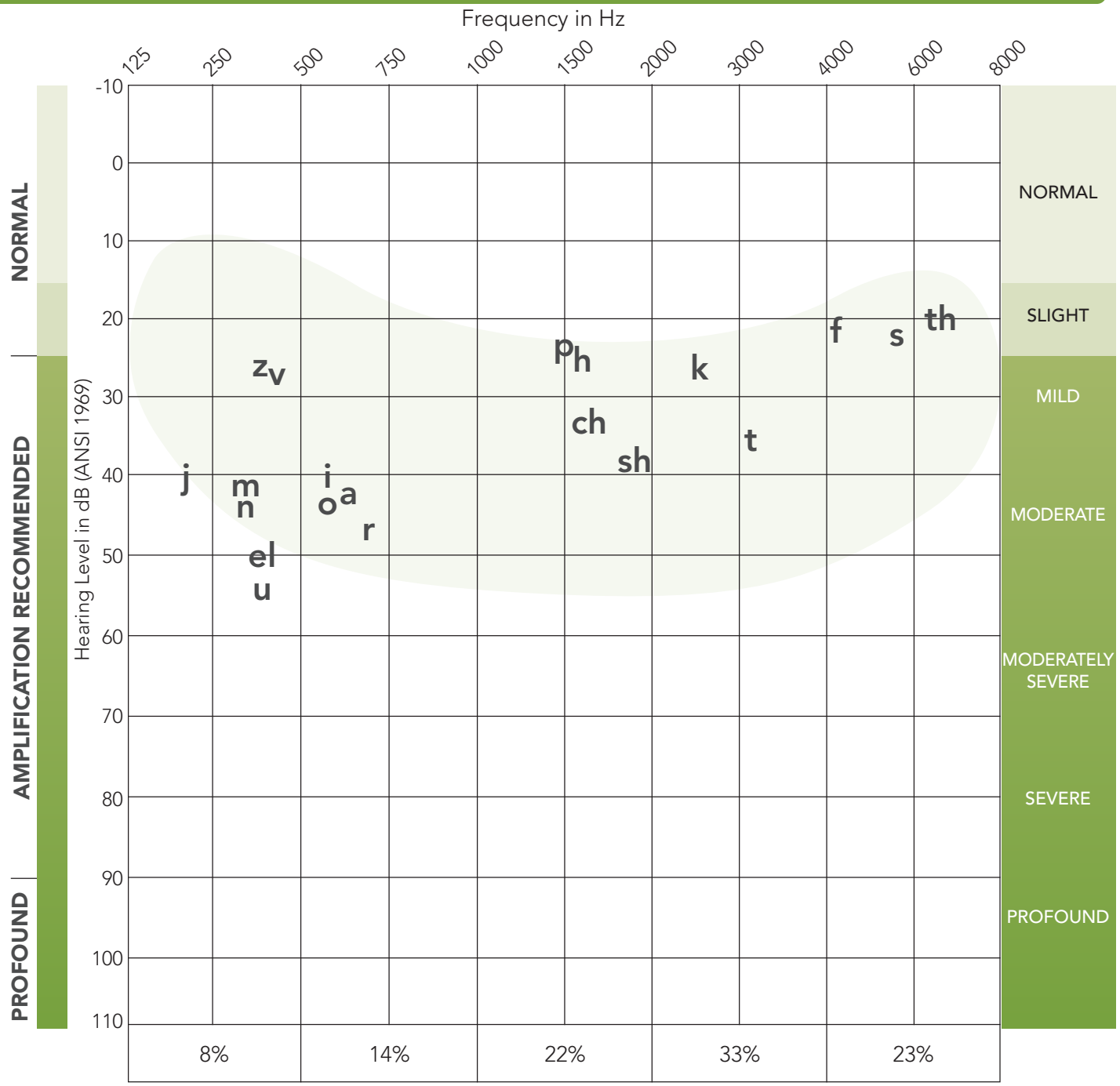
- Visible congenital or traumatic deformity of the ear? ☐ Yes ☐ No
- Visible evidence of significant cerumen accumulation or a foreign body in the ear canal? ☐ Yes ☐ No
- Any history of, or active drainage from the ear within the past 90 days? ☐ Yes ☐ No
- Any history of sudden or rapidly progressive hearing loss within the previous 90 days? ☐ Yes ☐ No
- Have you experienced any acute or chronic dizziness? ☐ Yes ☐ No
- Is there a unilateral hearing loss of sudden or recent onset within the past 90 days? ☐ Yes ☐ No
- Have you experienced any pain or discomfort? ☐ Yes ☐ No
- Audiometric air-bone gap equal to or greater than, 15dB at 500 Hz, 1000 Hz and 2000 Hz? ☐ Yes ☐ No

If the answer is "Yes" to any of these questions, patients must be referred to a physician or ear specialist prior to a hearing instrument fitting.

Notes: _____

_____

Patient's Test Results



IMPORTANCE TO SPEECH INTELLIGIBILITY

WORD RECOGNITION TEST RESULTS

EAR	UCL (HTL)		MCL (HTL)		SRT (HTL)	% CORRECT	PRESENT LEVEL
RIGHT							
LEFT							
BINAURAL	L	R	L	R			

Test Environment
Ambient Noise Level
in (dB SPL)

RESPONSE						NO RESPONSE					
	Left	Right		Left	Right		Left	Right		Left	Right
Air Conduction Unmasked	X	O	Bone Conduction Unmasked	>	<	Air Conduction Unmasked			Bone Conduction Unmasked		
Air Conduction Masked	□	△	Bone Conduction Masked	]	[	Air Conduction Masked			Bone Conduction Masked		
UCL	⊓	⊓									

Provider: _____ Date: _____

Speech Understanding Assessment

Speech Understanding Assessment (SPONDEE WORDS)

Playground ____	Duckpond ____	Railroad ____
Pancake ____	Hotdog ____	Daybreak ____
Headlight ____	Workshop ____	Armchair ____
Farewell ____	Northwest ____	Inkwell ____
Pancake ____	Inkwell ____	Mushroom ____
Mushroom ____	Baseball ____	Stairway ____
Headlight ____	Airplane ____	Eardrum ____
Whitewash ____	Woodwork ____	Toothbrush ____
Cowboy ____	Sidewalk ____	Eardrum ____
Drawbridge ____	Grandson ____	Cowboy ____
Woodwork ____	Padlock ____	Hotdog ____
Sidewalk ____	Hardware ____	Sunset ____
Sunset ____	Mousetrap ____	Horseshoe ____
Greyhound ____	Horseshoe ____	Workshop ____

FAMILIAR VOICE TEST

WORD LIST

1.) Tax ____	10.) Fist ____	19.) Cease ____
2.) Teeth ____	11.) Paste ____	20.) Pass ____
3.) Chase ____	12.) Space ____	21.) Thief ____
4.) Pot ____	13.) Chat ____	22.) Peace ____
5.) Fifth ____	14.) List ____	23.) Fat ____
6.) Peach ____	15.) Teach ____	24.) Shape ____
7.) Fast ____	16.) Safe ____	25.) Pitch ____
8.) Chief ____	17.) Feast ____	____
9.) Feet ____	18.) Wipe ____	____

NU #6 half-lists, Forms A, B, C, D, arranged with the 10 most difficult words listed first.

Right: Left:	Right: Left:	Binaural	Aided
1. BASE ____	1. GUN ____	1. PASS ____	1. PAD ____
2. MESS ____	2. JUG ____	2. DOLL ____	2. MATCH ____
3. CAUSE ____	3. SHEEP ____	3. BACK ____	3. DEEP ____
4. MOP ____	4. FIVE ____	4. RED ____	4. CHIEF ____
5. GOOD ____	5. RUSH ____	5. WASH ____	5. GAZE ____
6. LUCK ____	6. RAT ____	6. SOUR ____	6. ROT ____
7. WALK ____	7. VOID ____	7. BONE ____	7. HAZE ____
8. YOUTH ____	8. WIRE ____	8. GET ____	8. CALM ____
9. PAIN ____	9. HALF ____	9. WHEAT ____	9. SOUTH ____
10. DATE ____	10. NOTE ____	10. THUMB ____	10. NICE ____
11. PEARL ____	11. WHEN ____	11. SAIL ____	11. CHAIR ____
12. SEARCH ____	12. NAME ____	12. YEARN ____	12. SHAWL ____
13. DITCH ____	13. THIN ____	13. WIFE ____	13. SAID ____
14. TALK ____	14. TELL ____	14. SUCH ____	14. GOAL ____
15. RING ____	15. BAR ____	15. NEAT ____	15. SOAP ____
16. GERM ____	16. MOUSE ____	16. PEG ____	16. WAG ____
17. LIFE ____	17. HIRE ____	17. MOB ____	17. KEG ____
18. TEAM ____	18. CAB ____	18. GAS ____	18. WITH ____
19. LID ____	19. HIT ____	19. CHECK ____	19. LOAF ____
20. POLE ____	20. CHAT ____	20. JOIN ____	20. READ ____
21. ROAD ____	21. PHONE ____	21. LEASE ____	21. HATE ____
22. SHALL ____	22. SOUP ____	22. LONG ____	22. RAIN ____
23. LATE ____	23. DODGE ____	23. CHAIN ____	23. NUMB ____
24. CHEEK ____	24. SEIZE ____	24. KILL ____	24. VOICE ____
25. BEG ____	25. COOL ____	25. HOLE ____	25. LORE ____

Everyday Speech Sentences

1. Let's get a cup of coffee.
2. I hate driving at night.
3. Believe me!
4. Let's get out of here before it's too late.
5. How do you know?
6. Children like candy.
7. You can catch the bus across the street.
8. I'll think it over.
9. How do you spell your name?
10. Stop fooling around.
11. They're not listed in the new phonebook.
12. Mother cut the birthday cake.
13. School finished early today.
14. The bath towel was wet.
15. The dog came back.
16. The shirts are hanging in the closet.
17. The train stops at the station.
18. The cat is sitting on the bed.
19. They are buying some bread.
20. He played with his train.
21. A mouse ran down the hole.
22. He cut his finger.
23. Snow falls at Christmas.
24. Milk comes in a carton.
25. A boy fell from the window.

EVALUATION RESULTS Check one: ☐ Test with loss ☐ Test no loss ☐ Medical referral

Recommendations:

Right Hearing Instrument _____ Comments _____

Left Hearing Instrument _____ Comments _____