

Patient: _____

Date: _____
(Month/Day/Year)

Examiner: _____

Otososcopic Examination

CANALS

		CLEAR	PARTIAL OBSTRUCTION	FULL OBSTRUCTION
R. Ear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L. Ear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Speech Testing Audiometric

	Right Ear	Left Ear
MCL	_____ dB HL	_____ dB HL
UCL	_____ dB HL	_____ dB HL
WRS	_____ %	_____ %
SRT	_____ dB HL	_____ dB HL

Client Response Accuracy

Excellent Good Fair Poor

Live Voice Sound Booth

CD Inserts

TDH39

Acoustic Reflexes

Hz	L	R
500		
1000		
2000		
4000		

Tympanometry

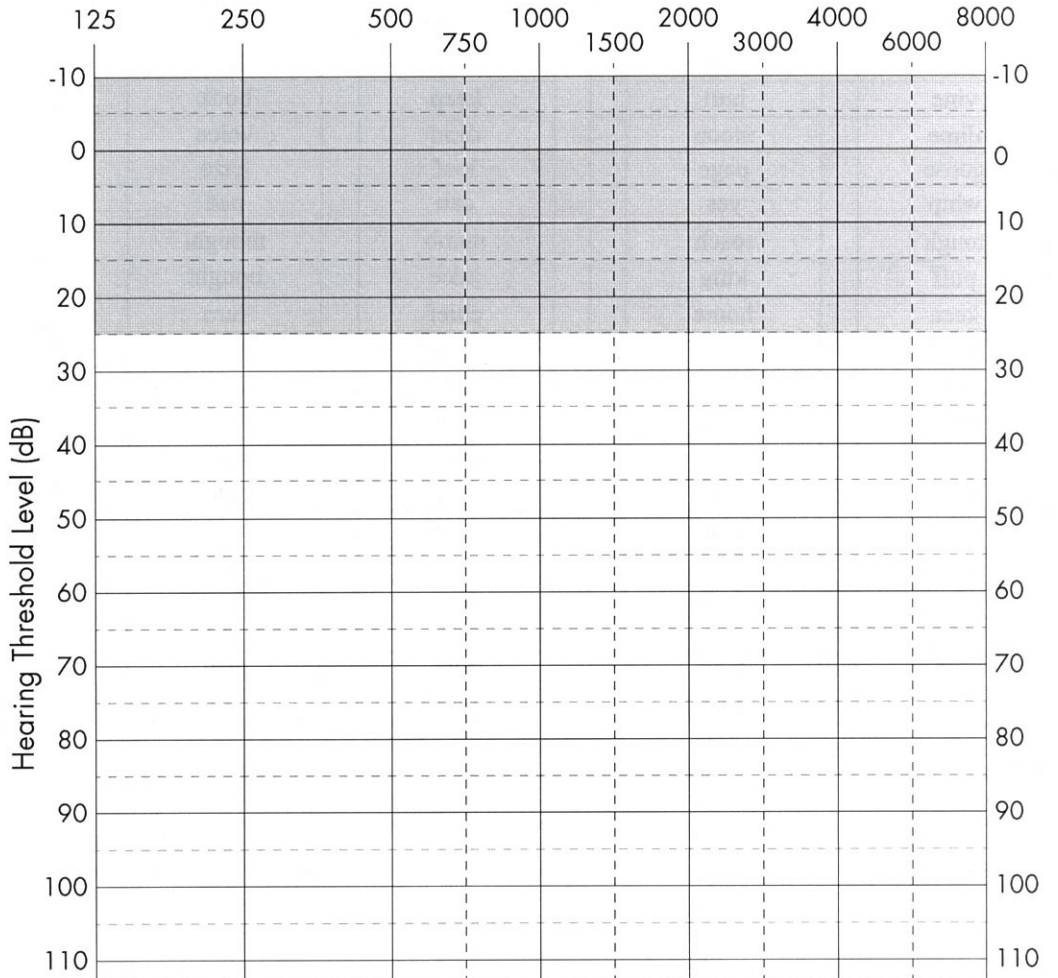
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AIR BONE

L	R		L	R
×	○	UNMASKED	>	<
×	○	NO RESPONSE	∞	∞
□	△	MASKED]	[
□	△	NO RESPONSE	∞	∞

Puretone Audiometry

Frequency in hertz (Hz)



Masking

Air								
Bone						Left		
	250Hz	500Hz	1K	2K	3K	4K	6K	8K
Air								
Bone						Right		

Notes