Auditory Screening

Date: ____ Screener: ____________________

Complete questionnaire and screening. Findings that meet criteria outlined in HSB 15.03.25.01 will be referred to audiologist as ordered below.

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 worsening of hearing loss?			Yes	No
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 prolonged exposure to loud noises?			Yes	No
Have you had recent drainage from your ear(s)?			Yes	No
If yes,	Right	Left	Both	
Do you have pain or discomfort in your ear(s)?			Yes	No
If yes,	Right	Left	Both	
Do you desire accommodation?	Yes	No*		

*If no, Complete DC4-711A

Screener signature and date ________________________ Clinician signature and date ________________________

INMATE NAME:_______________________________

DC#: ______________RACE: __________SEX: ______

DATE OF BIRTH:______________________________

INSTITUTION: