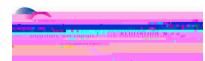


Have you had any of the following evaluations at any other clinic in the past?

Speech, Voice, Language Evaluation	YES	NO	Audiological/Hearing Evaluation	YES	NO
Name of clinic:			Name of clinic:		
Address:			Address:		
Phone number:			Phone number:		
Date of evaluation:					

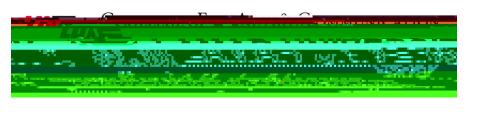




Hearingloss	Difficulty hearing in noise		Difficulty understanding speech in noise
Exposure to loud sounds	Buzzing/ringing in ears		Dizziness
Interested in hearing aids	Feeling of ear fullness		Ear discharge or pain

Excessive ear wax

Other:



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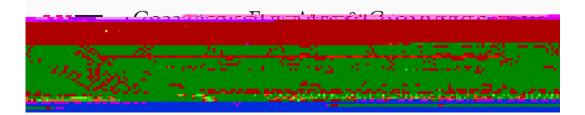
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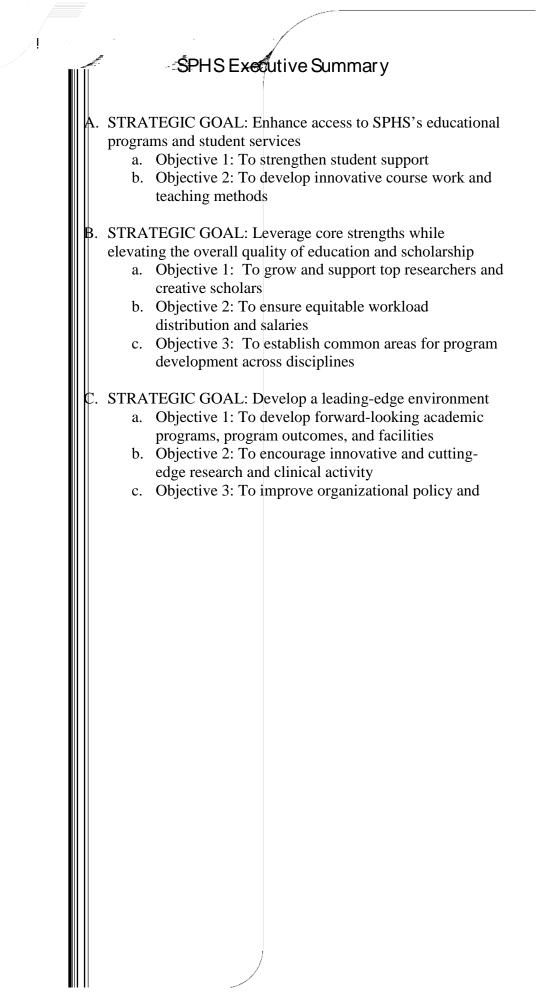




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