

Courriel : secretary@deafsport.be
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BDC AUDIOGRAM

Family Name : _____ First Name : _____

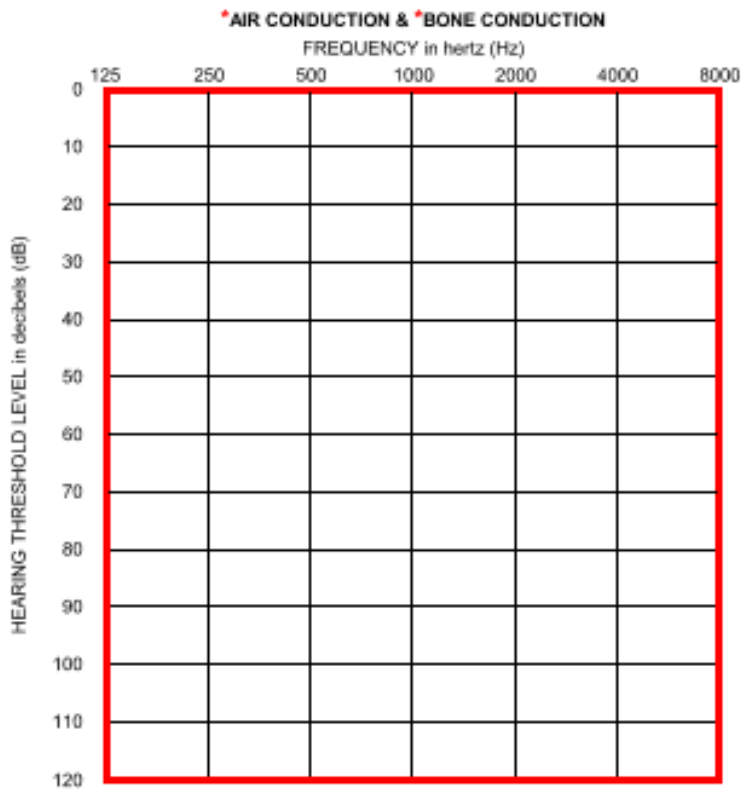
Date of Birth : _____ Gender : Male Female

Below is complete by audiologist only

*Audiometer: _____

*Date of Examination: _____
(day / month / year)

*Calibration: ☐ ANSI 1969 ☐ ISO 1964
☐ Other: _____



*IMPEDANCE TYMPANOMETRY				
Ear	Canal Vol.	Peak Comp.	Gradient	Pres. Peak
RIGHT				
LEFT				

*REFLEXOMETRY					
Side Equals Probe Ear					
RIGHT	Stim.	500	1000	2000	4000
	Ipsi				
	Contra				
LEFT	Stim.	500	1000	2000	4000
	Ipsi				
	Contra				

KEY TO SYMBOLS				
Ear	Air	Air-masked	Bone	Bone-masked
RIGHT (red)	O	△	<	[
LEFT (blue)	X	□	>	]
No Response			NR	

PURE TONE AVERAGE (500-1000-2000 Hz)		
Ear	Air	Bone
RIGHT		
LEFT		

TYPE OF HEARING LOSS (Check one for each ear with an "X")				
Ear	Sensori-neural	Conductive	Mixed	Cochlear Implant
RIGHT				
LEFT				

CLINICAL USE ONLY	
ID:	_____
Data Entered By:	_____
Audiologist:	_____
Signature	

COMMENTS :

Send this audiogram form to your National Deaf Sports Federation for review : secretary@deafsport.be