

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

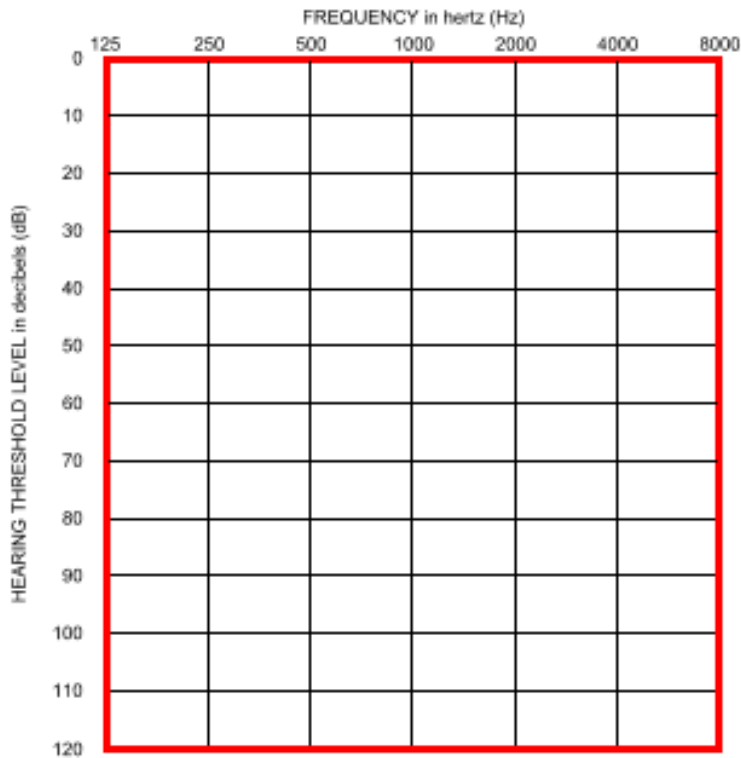
*Audiometer: _____

*Date of
Examination: _____

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

(day / month / year)

*AIR CONDUCTION & *BONE CONDUCTION



*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					

PURE TONE AVERAGE

(500-1000-2000 Hz)

Ear	Air	Bone
RIGHT		
LEFT		

KEY TO SYMBOLS

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

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

[Sign Here](#)

COMMENTS :

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