

AUDIOMETRIC HISTORY FORM

Employee

Name: _____ Date: _____

DOB: _____ Age: _____ Company: _____

Department: _____ Shift: _____ Job Title: _____

Type of Test: (Please 4 one box.)

- PREPLACEMENT BASELINE (Initial) ANNUAL RETEST TERMINATION OTHER

EMPLOYEE HISTORY (Please 4 appropriate boxes.)

Have you been exposed to noise within the last 14 hours?

- Yes No Explain: _____

How do you rate your hearing?

- Unknown Very poor Average Good Very good

Hearing Protection, Do you wear while at work?

- Not used Seldom Used Used sometimes 1/2 time Usually used Always used

If yes, what type of hearing protection do you wear? Earplugs Earmuffs Both

Brand? _____

MEDICAL HISTORY

10. Ear pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____	25. Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
11. Draining ear	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____	26. Measles	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
12. Dizziness/imbalance	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____	27. Meningitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
13. Severe ringing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____	28. Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
14. Sudden hearing loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____	29. Kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
15. Fluctuating loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____	30. Visible wax/object	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
16. Fullness/discomfort	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____	31. Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
17. History of prior disease/ear problem	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____	32. Family hearing loss	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
18. Recent prescription drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____	33. High noise exposure today	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
19. High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____	34. History of prior ear disease before test	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
20. See MD for ears	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____	35. Head cold today	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
21. Ear surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____	36. Military service	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
22. Unconsciousness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____	37. Noisy hobbies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
23. Wear hearing aid	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____	38. Loud music/headphones	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____
24. Mumps	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____	39. Firearms/guns	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain _____

MEDICATIONS (Past & Present)

(Please 4 appropriate boxes.)

Aspirin, Bufferin, Excedrin (more than 6/day)

Neomycin

Streptomycin

Gentamycin

Quinine

Explain 4 answers: _____

Employee Signature

Date

OTOSCOPIC EXAM:

Right: Normal Abnormal _____ Examiners Initials _____

Left: Normal Abnormal _____ Examiners Initials _____