Audiometry Questionnaire

Last 4 Only

Name: _____ SS# _____ DOB: _____ Age: _____

Date: _____ Job Title: _____

When was your last exposure to noise requiring hearing protection: ☐ More than 14 hrs ago ☐ Less than 14 hrs ago

General Health

Serious Illness ☐ Yes ☐ No **If yes, describe:** _____

Head injury with loss of consciousness? ☐ Yes ☐ No

History of allergy problems? ☐ Yes ☐ No

Cold/flu symptoms in last 2 weeks? ☐ Yes ☐ No

Medications taken in the last month: _____

Have you ever had any of the following?

Measles	☐ Yes	☐ No	Mumps	☐ Yes	☐ No
Scarlet Fever	☐ Yes	☐ No	Meningitis	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No

Hearing and Hearing Symptoms

Do you have a history of hearing loss (☐ work-related / ☐ military-related) ☐ Yes ☐ No

Do you have a family member who had hearing loss before the age of 50? ☐ Yes ☐ No

Repeated ear infections in the past? ☐ Yes ☐ No

Have you had previous ear surgery? ☐ Yes ☐ No

Do you have frequent or severe dizziness? ☐ Yes ☐ No

Do you have ringing in your ears? ☐ Left ☐ Right ☐ Both ☐ None

Punctured eardrum? ☐ Left ☐ Right ☐ Both ☐ None

Do you have current ear pain? ☐ Left ☐ Right ☐ Both ☐ None

Do you use a hearing aid? ☐ Left ☐ Right ☐ Both ☐ None

Current Noise Exposure at Work

Do you work in a noisy environment? ☐ Yes ☐ No

Describe location: _____

Is your exposure continuous? ☐ Yes ☐ No

Or is your exposure intermittent? ☐ Yes ☐ No

Do you wear: ☐ Ear Plugs ☐ Ear Muffs ☐ Any other device ☐ Yes ☐ No

If yes, describe usage:

At work I wear protection: ☐ All the time ☐ Sometimes ☐ Occasionally ☐ _____

Non-work Environment

Military Service?	☐ Yes	☐ No
Listen to loud music or play in a band?	☐ Yes	☐ No
Do you or have you shot firearms?	☐ Yes	☐ No
Do you scuba dive?	☐ Yes	☐ No
Fly an aircraft, or drive a race car?	☐ Yes	☐ No
Do you have noisy hobbies (motorcycles or power tools)?	☐ Yes	☐ No
Do you use farm or construction equipment?	☐ Yes	☐ No
Have you worked at a noisy job prior to your current job?	☐ Yes	☐ No
Did you wear earplugs or other devices	☐ Yes	☐ No
Do you have a second job that is noisy?	☐ Yes	☐ No

Employee Signature: _____ **Date: _____**

Clinician Review: _____ **Date: _____**

Comments:

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