

AUDIOMETRIC HISTORY

Date: _____

Employee Name: _____ SSN: _____ Sex: _____

Date of Hire: _____

Company Name: _____ Job Title: _____

How Do You Rate Your Hearing:

- Good
- Fair
- Poor
- Difficult to Hear in Crowds
- Difficult to Hear Safety Alarms

Current Hearing Protection Used:

- None
- Ear Plugs
- Ear Muffs
- Both Plugs and Muffs
- Other: _____

Reason For Test:

- Pre-employment
- Annual
- Baseline
- Retest
- Exit

Mark an "X" in the NOW, PAST, or NEVER box next to each item:

NOW	PAST	NEVER	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Earaches
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Ear Ringing (Tinnitus)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Dizziness (Vertigo)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head Injury (with unconsciousness)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Fever (Over 104° F)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear Drainage
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear Surgery Specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear Injury Specify: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Problems from Medication
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear Infections
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bad Cold Today
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Asthma Attacks
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Trouble hearing in Right Ear
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Trouble hearing in Left Ear
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Aid: Right _____ Left _____

NON-WORK EXPOSURE TO NOISE: Do/did you have significant exposure to any of the following without hearing protection outside of work? (Mark and "X" in the NOW, PAST, or NEVER box next to each item.)

NOW	PAST	NEVER	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gun Fire
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chainsaws/Power Tools
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heavy Equipment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aircraft
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hunting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loud Music
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Car Racing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Engine Work/Tractor/Auto
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pilot a Plane

 Employee Signature Date

OTOSCOPIC EXAMINATION

TO BE COMPLETED BY PHYSICIAN/TECHNICIAN AT TIME OF OTOSCOPIC EXAMINATION.

HAS THE WORKER:

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Been working prior to examination?
<input type="checkbox"/>	<input type="checkbox"/>	Been exposed to noise 14 hours prior to test? If Yes, indicate the number of hours: _____
<input type="checkbox"/>	<input type="checkbox"/>	Had an audiometric test in the last year?
<input type="checkbox"/>	<input type="checkbox"/>	Had an audiometric test over 1 year ago?
<input type="checkbox"/>	<input type="checkbox"/>	It is unknown whether an audiometric test had been performed.

Check N (Normal) or A (Abnormal) for each. If A (Abnormal) is checked, describe the abnormality in the space provided.

	RIGHT	LEFT	DESCRIBE ABNORMAL
External Ear	[N] [A]	[N] [A]	_____
Ear Canal	[N] [A]	[N] [A]	_____
Ear Drum	[N] [A]	[N] [A]	_____

ATTACH AUDIOGRAM