Lehigh Valley Health Network
A PASSION FOR BETTER MEDICINE.

HealthWorks

AUDIOMETRIC HISTORY

Date: _____

Employee Name: _____ **SSN:** _____ **DOB:** _____ **Sex**: _____

Company Name: _____ **Date of Hire:** _____ **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	
❑	❑	❑	Frequent Earaches
❑	❑	❑	Excessive Ear Ringing (Tinnitus)
❑	❑	❑	Excessive Dizziness (Vertigo)
❑	❑	❑	Head Injury (with unconsciousness)
❑	❑	❑	High Fever (Over 104° F)
❑	❑	❑	Ear Drainage
❑	❑	❑	Ear Surgery Specify: _____
❑	❑	❑	Ear Injury Specify: _____
❑	❑	❑	Sinus Trouble
❑	❑	❑	Allergies/Hay Fever
❑	❑	❑	Hearing Problems from Medication
❑	❑	❑	Ear Infections
❑	❑	❑	Bad Cold Today
❑	❑	❑	Frequent Asthma Attacks
❑	❑	❑	Trouble hearing in Right Ear
❑	❑	❑	Trouble hearing in Left Ear
❑	❑	❑	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 an "X" in the NOW, PAST, or NEVER box next to each item.

NOW	PAST	NEVER	
❑	❑	❑	Gun Fire
❑	❑	❑	Chainsaws/Power Tools
❑	❑	❑	Heavy Equipment
❑	❑	❑	Aircraft
❑	❑	❑	Hunting
❑	❑	❑	Loud Music
❑	❑	❑	Car Racing
❑	❑	❑	Engine Work/Tractor/Auto
❑	❑	❑	Pilot a Plane

_____
Employee Signature **Date**

OTOSCOPIC EXAMINATION

TO BE COMPLETED BY PHYSICIAN/TECHNICIAN AT TIME OF OTOSCIPIC EXAMINATION.
HAS THE WORKER:

YES	NO	
❑	❑	Been working prior to examination?
❑	❑	Been exposed to noise 14 hours prior to test? If Yes, indicate the number of hours: _____
❑	❑	Had an audiometric test in the last year?
❑	❑	Had an audiometric test over 1 year ago?
❑	❑	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