

OCCUPATIONAL MEDICINE SERVICES - BASELINE AUDIOGRAM

NAME _____ DATE OF BIRTH _____

EMPLOYER / POTENTIAL EMPLOYER _____ JOB TITLE _____

OCCUPATIONAL ACOUSTIC EXPOSURE

How do you rate your own hearing? (Circle one)	GOOD / FAIR / POOR
If other than Good, why? _____	
Have you ever seen a doctor for ear trouble?	YES / NO
If YES, who and when? _____	
Has there been anyone in your family with a hearing loss before age 50?	YES / NO
If YES, who and when? _____	
Have you ever taken <u>Streptomycin</u> antibiotics?	YES / NO
Have you been exposed to any loud noises (≥ 85 dB) in the past 14 hours?	YES / NO
Have you ever worked in a noisy area or been required to wear hearing protection?	YES / NO
If YES, please answer: Occupation: _____ How long at this occupation?: _____	
Was ear protection provided?	YES / NO
Was ear protection worn?	YES / NO
Type worn: (Circle all that apply) PLUGS / MUFFS / OTHER: _____	

PERSONAL AUDITORY HISTORY

Do you <u>currently</u> have:	
A cold	YES / NO
Sinus infection	YES / NO
Do you currently have or have had any of the following conditions in the past:	
A hearing aid	YES / NO
Drainage from ear	YES / NO
Ringing in Ears (Tinnitus)	YES / NO
Excessive Wax	YES / NO
Allergies	YES / NO
Dizziness / vertigo	YES / NO
Earaches / ear pain	YES / NO
Mumps	YES / NO
Ear Infections	YES / NO
Measles	YES / NO
Tubes in Ears	YES / NO
Scarlet fever	YES / NO
Head Injury	YES / NO
Perforated (ruptured) ear drum	YES / NO

ATTACH RESULTS HERE

PERSONAL ACOUSTIC EXPOSURE

Circle YES or NO if you use or participate in the following:	
Firearms	YES / NO
Power tools	YES / NO
Travel by helicopter	YES / NO
Ride a motorcycle	YES / NO
Repair motors	YES / NO
Race motorized vehicles	YES / NO
Airboats	YES / NO
Inboard or outboard motors	YES / NO
Earphones to listen to music	YES / NO
Play musical instruments	YES / NO
What instrument _____	
Scuba dive	YES / NO
Greatest depth _____ Ft.	
Been in the military	YES / NO
If yes, which division? _____	