

Audio History Questionnaire

Name (Last, First): _____ Date of Birth: _____

Social Security Number: _____ - _____ - _____ Company: _____

Hire Date: _____

Are you aware of any hearing loss:					Yes	No
If yes, which ear (circle one):				Right	Left	Both
Have you had your hearing tested?					Yes	No
If yes,		Where:		When:		
Do you have a relative with hearing loss?					Yes	No
Have you ever worked in a noisy environment?					Yes	No
If yes,		Where:		Job:		How many years:
Have you had dizziness or balance problems?					Yes	No
Do you have ringing or roaring in your ears?					Yes	No
Do you have excessive ear wax?					Yes	No
Do you have earaches or ear drainage?					Yes	No
Have you had exposure to firearms?					Yes	No
If yes,		Type of gun:		Rounds/yr:		Number of years:
Have you had a severe head injury?					Yes	No
Are you taking prescription medication?					Yes	No
If yes,		What:				
Do you have any noisy hobbies?					Yes	No
If yes,		What:				
Have you been in the military?					Yes	No
If yes,		Branch:		Job:		Dates Served:
Do you wear ear protectors around noise?					Yes	No
Have you had recent exposure to loud noise without ear protection? (14 hours)					Yes	No
Recent cold?					Yes	No
Have you recently seen a physician for hearing?					Yes	No
If yes,		When:		Where:		