Name:_______________________________________ Date: ________________

Employer: __________________________ Job Title: ________________________

When was your last exposure to noise:________________________________

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

Scarlet Fever ☐ yes ☐ no

Diabetes ☐ yes ☐ no

Mumps ☐ yes ☐ no

Meningitis ☐ yes ☐ no

High Blood Pressure ☐ yes ☐ no

Hearing and hearing symptoms

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:__________________________________

Continuous exposure? ☐ yes ☐ no

Intermittent exposure? ☐ yes ☐ no

Do you wear ear plugs or any other device? ☐ yes ☐ no

If **yes describe:**______________________________

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

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

Other: ex. 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:____