



Audiometric History

Please complete form on the day of testing

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Must Be Completed Using PEN! Pencil Not Accepted.

DATE of TEST _____

NAME _____ COMPANY _____
 ADDRESS _____ SS# _____ SEX: M F
 _____ DATE of BIRTH _____ AGE _____

Please NOTE: Results of this testing will be provided to your employer.

Yes No Have you been exposed to loud noise today? If Yes, how may hours? _____
 Yes No Did you wear hearing protection today? What kind?

Yes	No	Have you had, or do you now have . .	Comments
		Ear pain?	
		Ear Drainage?	
		Dizziness?	
		Ringing in ears?	
		Sudden hearing loss?	
		Hearing loss that comes and goes?	
		Fullness and/or discomfort in ears?	
		Ear problems from ear plugs or muffs?	
		Wax or object in ear canal?	
		Ear problems you have seen a doctor for?	
		Ear, head, or neck surgery?	
		Unconscious or head injury?	
		Prescription hearing aid?	
		Mumps?	
		Scarlet Fever?	
		Someone in your family with a hearing loss? Who?	
		Head cold today?	
		Military Service?	
		Noisy hobbies? (please list)	
		Loud music and/or headphone use?	
		Previous job with loud noise? What was that job?	

Signature _____ **Date** _____

Otoscopic Screening:

Left Ear:	I = Eardrum intact	Right Ear:	I = Eardrum intact
	P = Possible perforation		P = Possible perforation
	D = Possible disease		D = Possible disease
	B = Blockage		B = Blockage
	F = Possible foreign body		F = Possible foreign body
	O = Partial obstruction (cerumen)		O = Partial obstruction (cerumen)
	S = Scarring		S = Scarring

Examiner Signature _____ **Date** _____