Audio Questionnaire

Employee Information:

Name:_____ Today's Date: _____
Employer:_____ Social Security Number: _____
Date of Birth : Gender: Male ☐ Female ☐
How many hours since your last noise exposure? Less than 14 hrs. ☐ More than 14 hrs. ☐ Unknown☐
Do you use hearing protection? Yes ☐ No ☐ What type? Plugs ☐ Muffs ☐ Both ☐
How often do you use hearing protection? Always ☐ Not used ☐ Sometimes ☐

Preferred Testing Language:
English ☐ Spanish ☐ Vietnamese ☐ Cambodian ☐ Bosnian ☐ Korean ☐ Arabic ☐ French ☐ German ☐
Polish ☐ Italian ☐ Japanese ☐ Russian ☐ Hindi ☐ Tibetan ☐ Somali ☐ Tagalog ☐ Hmong ☐

Medical History **Please check your response**

1. Have you recently experienced pain in either ear? - - - - - - - - - - - - - ☐ Right ☐Left ☐Both ☐No
2. Have you recently experienced a draining ear? - - - - - - - - - - - - - - - ☐ Right ☐Left ☐Both ☐No
3. Have you recently experienced dizziness? - ☐ Yes ☐No
4. Have you recently experienced severe ringing in your ears? - - - - - - - - ☐ Right ☐Left ☐Both ☐No
5. Have you recently experienced sudden hearing loss? - - - - - - - - - - - - ☐ Right ☐Left ☐Both ☐No
6. Have you recently experienced fluctuating hearing loss? - - - - - - - - - - ☐ Right ☐Left ☐Both ☐No
7. Have you recently experienced ear fullness or discomfort? - - - - - - - - - ☐ Right ☐Left ☐Both ☐No
8. Have you recently had problems wearing hearing protection? - - - - - - - - - - - - - - - - ☐ Yes ☐No
9. Are you currently suffering from a cold or allergies? - ☐ Yes ☐No
10. Are you currently taking over-the-counter medications for cold or allergies? - - - - - - - ☐ Yes ☐ No

Complete below only if a follow-up test) **Please check your response**

1. Have you ever served in the military? - ☐ Yes ☐No
2. Have you ever been to a doctor for an ear-related problem? - - - - - - - ☐ Right ☐ Left ☐ Both ☐ No
3. Have you ever had a severe head injury? - ☐ Yes ☐No
4. Have you ever had measles? - ☐ Yes ☐No
5. Have you ever had mumps? - ☐ Yes ☐No
6. Have you ever had kidney disease? - ☐ Yes ☐No
7. Have you ever had scarlet fever? - ☐ Yes ☐No
8. Have you ever had meningitis? - ☐ Yes ☐No
9. Do you have diabetes? - ☐ Yes ☐No
10. Do you have high blood pressure? - ☐ Yes ☐No
11. Do you have an existing hearing problem? - ☐ Yes ☐No
12. Do you shoot guns or hunt? - ☐ Yes ☐No
13. Do you wear a hearing aid? - ☐ Right ☐ Left ☐ Both ☐ No
14. Do you participate in loud activities (music, motorcycles, power tools)? - - - - - - - - - ☐ Yes ☐No
15. Does any of your immediate family have hearing problems? - - - - - - - - - - - - - - - - - ☐ Yes ☐No
16. Have you ever had ear surgery? - ☐ Right ☐ Left ☐ Both ☐ No
17. Do you have frequent ear infections? - ☐ Right ☐ Left ☐ Both ☐ No

Employee Signature: _____

EXAMINER ONLY:
Does employee have visible wax or object in ear? **Right ear:** Yes ☐ No ☐ **Left ear:** Yes ☐ No ☐

Examiner Name: _____ **Date:** _____