Frederick Health
Employer Solutions

AUDIOMETRIC HISTORY FORM

Employee
Name:_____ Date:_____
DOB:_____ Age:_____ Company:_____
Department:_____ Shift:_____ Job Title:_____

Type of Test: **(Please 4 one box.)**

☐ PREPLACEMENT ☐ BASELINE (Initial) ☐ ANNUAL ☐ RETEST ☐ TERMINATION ☐ OTHER

EMPLOYEE HISTORY **(Please 4 appropriate boxes.)**

Have you been exposed to noise within the last 14 hours?
☐ Yes ☐ No Explain:_____

How do you rate your hearing? ☐ Unknown ☐ Very poor ☐ Average ☐ Good ☐ Very good

Hearing Protection, Do you wear while at work?
☐ Not used ☐ Seldom Used ☐ Used sometimes ☐ 1/2 time ☐ Usually used ☐ Always used
If yes, what type of hearing protection do you wear? ☐ Earplugs ☐ Earmuffs ☐ Both
Brand?_____

MEDICAL HISTORY

10. Ear pain	☐Yes☐No	Explain_____	25. Scarlet Fever	☐Yes ☐No	Explain _____
11. Draining ear	☐Yes☐No	Explain_____	26. Measles	☐Yes☐No	Explain_____
12. Dizziness/imbalance	☐Yes☐No	Explain_____	27. Meningitis	☐Yes☐No	Explain_____
13. Severe ringing	☐Yes☐No	Explain_____	28. Diabetes	☐Yes☐No	Explain_____
14. Sudden hearing loss	☐Yes☐No	Explain_____	29. Kidney disease	☐Yes☐No	Explain_____
15. Fluctuating loss	☐Yes☐No	Explain_____	30. Visible wax/object	☐Yes☐No	Explain_____
16. Fullness/discomfort	☐Yes☐No	Explain_____	31. Allergies	☐Yes☐No	Explain_____
17. History of prior disease/ear problem	☐Yes☐No	Explain_____	32. Family hearing loss	☐Yes☐No	Explain_____
18. Recent prescription drugs	☐Yes☐No	Explain_____	33. High noise exposure today	☐Yes☐No	Explain_____
19. High blood pressure	☐Yes☐No	Explain_____	34. History of prior ear disease before test	☐Yes☐No	Explain_____
20. See MD for ears	☐Yes☐No	Explain_____	35. Head cold today	☐Yes☐No	Explain_____
21. Ear surgery	☐Yes☐No	Explain_____	36. Military service	☐Yes☐No	Explain_____
22. Unconsciousness	☐Yes☐No	Explain_____	37. Noisy hobbies	☐Yes☐No	Explain_____
23. Wear hearing aid	☐Yes☐No	Explain_____	38. Loud music/headphones	☐Yes☐No	Explain_____
24. Mumps	☐Yes☐No	Explain_____	39. Firearms/guns	☐Yes☐No	Explain_____

MEDICATIONS ***(Past & Present)*** **(Please 4 appropriate boxes.)**

☐ Aspirin, Bufferin, Excedrin (more than 6/day)
☐ Neomycin ☐ Streptomycin ☐ Gentamycin ☐ Quinine

Explain 4answers:_____

_____ _____
Employee Signature ***Date***

OTOSCOPIC EXAM:

Right: ☐ Normal ☐ Abnormal _____Examiners Initials_____
Left: ☐ Normal ☐ Abnormal _____Examiners Initials_____