NOHS Medical Clinic

6732 E. 41st St., Tulsa, OK 74145
Voice: 918.794.4777 Fax: 918.794.4778

Audiometric Patient History Form

Date: _____ **SS#:** _____

Name: _____, _____, _____
(LAST) (FIRST) (MI)

Date of Birth: _____ **Male** ☐ **Female** ☐

Time Shift Started: _____ **AM/PM**

Hire Date: _____

Company: _____

Job Title:

Department: _____ _____

CIRCLE NUMBER ONLY IF IT HAS EVER APPLIED TO YOU AND IF SO, MARK THE CORRESPONDING BOXES
Circle items 10 – 18 only if it has applied to you within the *last 12 months.*
Circle items 19 – 39 if it has ever applied to you in your lifetime.

Left	Right	Both		Left	Right	Both	
☐	☐	☐	10. Ear Pain				25. Scarlet Fever
☐	☐	☐	11. Draining Ear				26. Measles
			12. Dizziness/Imbalance				27. Meningitis
☐	☐	☐	13. Severe Ringing				28. Diabetes
☐	☐	☐	14. Sudden Hearing Loss				29. Kidney Disease
☐	☐	☐	15. Fluctuating Loss	☐	☐	☐	30. Visible Wax Object
☐	☐	☐	16. Fullness/Discomfort				31. Allergies
☐	☐	☐	17. HPD/Ear Problem				32. Family Hearing Loss
☐	☐	☐	18. Prescription or over the counter drugs				33. High Noise Prior
			19. High Blood Pressure				34. No HPD before Test
☐	☐	☐	20. Seen Doctor for Ears				35. Head Cold Today
☐	☐	☐	21. Ear Surgery				36. Military Service
			22. Unconsciousness				37. Noisy Hobbies
☐	☐	☐	23. Wear Hearing Aid				38. Loud Music/Headphones
			24. Mumps				39. Firearms/Guns

Any additional comments: _____
_____

Do you wear hearing protection?: ☐Yes ☐ No **If yes, do you wear:** ☐ Ear Plugs ☐ Earmuffs ☐ Both

How do you rate your hearing?: ☐ Very Poor ☐ Poor ☐ Average ☐ Good ☐ Very Good

TECHNICIAN USE ONLY

Left							Right						
500	1K	2K	3K	4K	6K	8K	500	1K	2K	3K	4K	6K	8K
___	___	___	___	___	___	___	___	___	___	___	___	___	___

Technician ID: _____ **Audiometer ID:** _____
Calibration Date: _____ **Calibration Tech:** _____
Time of Test: _____ **Date:** _____
Technician Notes: _____
_____