National Occupational Health Services

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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	Righ t	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: ____
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