

# AUDIOMETRIC HEARING HISTORY FORM

## Minnesota Occupational Health

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Birth date: \_\_\_\_\_ Job Title: \_\_\_\_\_

### Noise Exposures

- | Yes                      | No                       |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Served in the military?<br>Branch _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Combat Duty?                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Skeet or trapshooting?                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Hunting?                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Loud Music?                              |
| <input type="checkbox"/> | <input type="checkbox"/> | Snowmobiling?                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Motorcycling?                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Chainsaw/heavy<br>equipment/power tools? |
| <input type="checkbox"/> | <input type="checkbox"/> | Other?<br>_____                          |

If yes to any of the above, how often?  
\_\_\_\_\_

Have you worked in any noisy environments?  
 Yes  No - If yes, what jobs?  
\_\_\_\_\_

How long did you work there?  
\_\_\_\_\_

Do you wear ear protectors on a regular basis for any of the above activities?  Yes  No

Have you been exposed to loud noise within the last 14 hours?  Yes  No

If yes, was ear protection worn?  Yes  No

Comments: \_\_\_\_\_  
\_\_\_\_\_

### Hearing Evaluation

Do you consider your hearing to be :  
 Good  Fair  Poor

Yes No Have you ever:

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Seen a doctor about your hearing?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Had your hearing tested?<br>If so, when? _____  |
| <input type="checkbox"/> | <input type="checkbox"/> | Had mumps?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Had an ear infection?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Had a draining ear?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Had ear surgery?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Had frequent dizziness?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use a hearing aid?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have high blood pressure?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have family members with hearing loss? If yes, who? _____<br>Age discovered? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a head injury with a loss of consciousness?                             |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you take more than 8 aspirin daily on a regular basis?                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had ringing noises in your ears?  |

If yes to any of the above, please explain:  
\_\_\_\_\_  
\_\_\_\_\_

Employee Signature: \_\_\_\_\_

Technician comments: \_\_\_\_\_  
\_\_\_\_\_

Technician signature: \_\_\_\_\_

Date: \_\_\_\_\_