Audiogram

INTEGRATED, COMPREHENSIVE OCCUPATIONAL HEALTH SERVICES

A division of Summit Orthopedics for over 20 years

Patient information:

1. Have you been exposed to loud noises in the last 14 hours without hearing protection?* ☐ Yes ☐ No
2. Do you have a cold today?** ☐ Yes ☐ No
3. Have you ever been told or noticed that you are hard of hearing? ☐ Yes ☐ No
4. Do you have ringing or buzzing in your ears? ☐ Yes ☐ No
5. Do you have a history of ear infections or surgery to your ears? ☐ Yes ☐ No
6. Do you normally use hearing protection at work? If so, what kind? ☐ Yes ☐ No
7. History: Please list below any past exposure to noise including military, jobs, hobbies or activities, and indicate whether you used hearing protection during these activities.

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☐ **Results attached on 2nd page**

☐ **Results attached on the right**

CLINIC STAFF TO COMPLETE

Ear exam done: ☐ Baseline ☐ Annual

Interpretations:

☐ Normal ☐ Standard Threshold Shift

☐ High Frequency Loss ☐ Other ____________

Recommendations:

☐ Hearing Protection ☐ Standard Threshold Shift

☐ Annual Hearing Test ☐ Other ____________

Comments:

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Examined by: ______________________________

Physician's signature: ______________________________

Date: _____ / _____ / _____
Month Day Year

Clinic Copy

Name: ______________________________

Job title: ______________________________

Noise Exposures

Served in military ☐ Yes ☐ No

Branch ______________________________

Combat duty ☐ Yes ☐ No

Skeet or trapshooting ☐ Yes ☐ No

Hunting ☐ Yes ☐ No

Loud music ☐ Yes ☐ No

Snowmobile ☐ Yes ☐ No

Motorcycle ☐ Yes ☐ No

Chainsaw/heavy equip/power tools ☐ Yes ☐ No

Other ______________________________

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 thelast 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

Have you ever:

Seen a doctor about your hearing ☐ Yes ☐ No

Had your hearing tested ☐ Yes ☐ No

If so, when? ______________________________

Had mumps ☐ Yes ☐ No

Had an ear infection ☐ Yes ☐ No

Had a draining ear ☐ Yes ☐ No

Had ear surgery ☐ Yes ☐ No

Had frequent dizziness ☐ Yes ☐ No

Do you use a hearing aid? ☐ Yes ☐ No

Do you have high blood pressure? ☐ Yes ☐ No

Have you ever had a head injury with a loss of consciousness? ☐ Yes ☐ No

Do you take more than eight aspirin daily on a regular basis? ☐ Yes ☐ No

Have you ever had ringing noises in your ears? ☐ Yes ☐ No

If yes to any of the above, please explain:

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Employee signature: ______________________________

Technician comments: ______________________________

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