

EXTENDED QUESTIONNAIRE FOR OSHA RECORDABLE HEARING LOSS DETERMINATION

Company:

City:

State:

Name: (Last, First, M.I.)

DOB:

Assessed Noise Exposure Level (TWA):

Do you work stationary with noise coming from one side?

Yes No; if yes, which ear is most involved? Left Right

Have you had a work-related injury/blast/explosion?

Yes No; if yes, please explain:

Do you wear a shoulder mounted radio?

Yes No; if yes, on which shoulder? Left Right

Have you received radiation or chemotherapy?

Yes No; if yes, please explain:

Do you work with Toluene, Xylene, Styrene?

Yes No; if yes, please explain:

Do you work a second job?

Yes No; if yes, please explain:

Have you had ear-related surgery?

Yes No; if yes, please explain:

OFF-THE-JOB ACTIVITIES	HEARING PROTECTION USED?			HOURS (PER WEEK, MONTH, OR YEAR)
Metal work/grinders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Varies	
Chain saw/chippers	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Varies	
Heavy equipment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Varies	
Air tools	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Varies	
Farm implements	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Varies	
Leaf blower/weed trimmer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Varies	
Motor sports (cars/boats/motorcycles)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Varies	
Aviation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Varies	
Firearms/hunting/target	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Varies	
Music	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Varies	
Personal music devices (e.g. iPod, etc)	<input type="checkbox"/> Yes	<input type="checkbox"/> No		

DIAGNOSED CONDITIONS/OTOLOGIC HISTORY

Kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Viral infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Meniere's disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Balance (Vestibular) disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Schwannoma (a.k.a. Acoustic Neuroma)	<input type="checkbox"/> Yes	<input type="checkbox"/> No; if yes, which ear? <input type="checkbox"/> Left <input type="checkbox"/> Right
Otosclerosis/Cholestoma/Ear infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No; if yes, which ear? <input type="checkbox"/> Left <input type="checkbox"/> Right
Perforated eardrum	<input type="checkbox"/> Yes	<input type="checkbox"/> No; if yes, which ear? <input type="checkbox"/> Left <input type="checkbox"/> Right

CURRENT CONDITIONS

Ear pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No; if yes, which ear? <input type="checkbox"/> Left <input type="checkbox"/> Right
Drainage from ear(s)	<input type="checkbox"/> Yes	<input type="checkbox"/> No; if yes, which ear? <input type="checkbox"/> Left <input type="checkbox"/> Right
Feeling of fullness in ear(s)	<input type="checkbox"/> Yes	<input type="checkbox"/> No; if yes, which ear? <input type="checkbox"/> Left <input type="checkbox"/> Right
Sudden/rapid hearing loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No; if yes, which ear? <input type="checkbox"/> Left <input type="checkbox"/> Right
Severe ringing	<input type="checkbox"/> Yes	<input type="checkbox"/> No; if yes, which ear? <input type="checkbox"/> Left <input type="checkbox"/> Right
Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No; if yes, which ear? <input type="checkbox"/> Left <input type="checkbox"/> Right

Employee Signature:

Date:

Thank you for completing this questionnaire

*****SITE CONTACT INFORMATION*****

Site Contact Name:

Site Contact Email address:

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