

Name _____ SSN# _____ DOB / / Sex Clock # _____ Date Hired _____

Company _____ Division _____ Location City _____ State _____ Plant _____

TEST NO. #	LEFT EAR						RIGHT EAR						
	50	100	200	300	400	600	50	100	200	300	400	600	800
1													
2													
3													
4													
5													
6													

INITIAL OTOLOGIC HISTORY
 Check YES or NO in all boxes. Explain YES answers in Comments.
UPDATE INSTRUCTIONS
 Enter only "Yes" responses. Indicate with ✓ through number entered at top of column to show that all questions were asked. The purpose of the update is to discover new developments or worsening of old complaints. Use phrases such as "do you now have a new complaint of" or "since the last test" to elicit new information.

OTOLOGIC HISTORY
 TEST #1 DATE: _____

- Are you currently experiencing?
- Noises in ears? (Ringing, Buzzing, Humming)
 - Dizziness?
 - Pain in ears?
 - Fluctuating, sudden rapid hearing loss?
 - Ear infections?
 - In your lifetime:
 - Have you ever been to an ear specialist?
 - Was ear surgery recommended or performed?
 - Have you had a head injury or unconsciousness?
 - Have you ever had: (circle those that you have had)
 - Measles
 - Mumps
 - Chicken Pox
 - Scarlet Fever
 - Diphtheria
 - Have you had large doses of antibiotics, quinine or aspirin for treatment of a serious medical condition?
 - Do you have a family history of hearing loss?
 - Have you worked at another job that was noisy? (previous employment)
 - Have you ever been exposed to gunfire? (hunting, trap shooting?)
How often?
 - Vrs Military Serv. _____ Branch _____ Job _____
- Presently:
- Do you have a noisy hobby? (loud music, motorcycling)
 - Do you have a hearing aid? Right _____ Left _____
 - Have you been away from your job noise 14 to 16 hours?
 - When working in high noise areas, do you wear hearing protection?

AUDIOMETRIC TEST INFORMATION				EMPLOYMENT INFORMATION					
SERIAL #	MAKE	MODEL	AUDIOMETER CALIBRATION DATE	★ TESTER NAME	DEPT.	JOB CLASS	SHIFT	NOISE LEVEL	H.P. REQ'D?

TEST QUESTION # _____

OTOLOGIC & OTOSCOPIC COMMENTS

OTOSCOPIC OBSERVATION:	1	2	3	4	5	6
a. Are ear canals obstructed?						
b. Are perforations present?						
c. Is other present?						

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