

**EXTENDED QUESTIONNAIRE FOR OSHA RECORDABLE HEARING LOSS DETERMINATION  
(PLEASE ANSWER ALL QUESTIONS)**

<b>Name:</b>	
<b>Company:</b>	
<b>Assessed Noise Exposure (TWA):</b>	<b>Shift Duration:</b> <input type="radio"/> 8 Hrs <input type="radio"/> 12 Hrs
1. What type of hearing protectors do you use at work? <input type="radio"/> None <input type="radio"/> Foam Earplugs <input type="radio"/> Ear Muffs <input type="radio"/> Canal Caps <input type="radio"/> Custom	
2. If known, what is the labelled attenuation (NRR) on your protectors?	
3. What percentage of time do you wear hearing protectors at work when exposed to noise?  <input type="radio"/> 0%-Never <input type="radio"/> 5-20%-Rarely <input type="radio"/> 25-50%-Occasionally <input type="radio"/> 55-75%-Most of the time <input type="radio"/> 80-95%-Often <input type="radio"/> 100%-Always	
4. Do you <i>currently</i> have any of the following ear related complaints?  <input type="radio"/> Ear Pain <input type="checkbox"/> Left Ear <input type="checkbox"/> Right Ear <input type="radio"/> Ear Drainage <input type="checkbox"/> Left Ear <input type="checkbox"/> Right Ear <input type="radio"/> Feeling Of Fullness <input type="checkbox"/> Left Ear <input type="checkbox"/> Right Ear <input type="radio"/> Sudden Hearing Loss <input type="checkbox"/> Left Ear <input type="checkbox"/> Right Ear <input type="radio"/> Severe Ringing In The Ear (s) <input type="checkbox"/> Left Ear <input type="checkbox"/> Right Ear	
5. Have you been diagnosed by a physician with any of the following?  <input type="radio"/> Kidney Disease <input type="radio"/> Viral Infection <input type="radio"/> Meniere's Disease <input type="radio"/> Vestibular Disorder <input type="radio"/> Schwannoma/Acoustic Neuroma <input type="checkbox"/> Left Ear <input type="checkbox"/> Right Ear <input type="radio"/> Otosclerosis <input type="checkbox"/> Left Ear <input type="checkbox"/> Right Ear <input type="radio"/> Cholesteatoma <input type="checkbox"/> Left Ear <input type="checkbox"/> Right Ear <input type="radio"/> Cancer/Chemotherapy/Radiation <input type="radio"/> Severe Allergies <input type="radio"/> Frequent Ear Wax Impaction <input type="checkbox"/> Left Ear <input type="checkbox"/> Right Ear <input type="radio"/> Ear Injury/Perforated Eardrum <input type="checkbox"/> Left Ear <input type="checkbox"/> Right Ear <input type="radio"/> Head Injury/Concussion	
6. Do you work with any of the following chemicals? <input type="radio"/> Toluene <input type="radio"/> Xylene <input type="radio"/> Styrene <input type="radio"/> Methyl Ethyl Ketone (MEK)	
7. Do you work in noise coming from one side? <input type="radio"/> No <input type="radio"/> Yes; If Yes, which ear is most affected? <input type="checkbox"/> Left Ear <input type="checkbox"/> Right Ear	
8. Do you wear a shoulder mounted radio? <input type="radio"/> No <input type="radio"/> Yes; If Yes, which position of the speaker best applies? <input type="checkbox"/> Closer to Left Ear <input type="checkbox"/> Closer to Right Ear <input type="checkbox"/> Positioned on Center of chest	

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<b>Name:</b>		
9. Have you been exposed to a work related blast? <input type="radio"/> No <input type="radio"/> Yes; If Yes which ear was most affected? <input type="checkbox"/> Left Ear <input type="checkbox"/> Right Ear		
10. Do you work a noisy second job? <input type="radio"/> No <input type="radio"/> Yes		
11. Have you served in the military? <input type="radio"/> No <input type="radio"/> Yes If Yes, Dates of service _____ Branch _____ Were you noise exposed? <input type="radio"/> No <input type="radio"/> Yes Did you wear hearing protection? <input type="radio"/> No <input type="radio"/> Yes		
12. Do you discharge firearms? <input type="radio"/> No <input type="radio"/> Yes If Yes, what type(s)? _____ If Yes, how many rounds a year? _____ If Yes, what type of shooting? <input type="radio"/> Hunting <input type="radio"/> Target <input type="radio"/> Both If Yes, do you wear hearing protection? <input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Varies		
13. Are you left or right handed? <input type="radio"/> Left <input type="radio"/> Right		
<b>14. Off-the-job activities</b>	<b>Do you use hearing protection when performing the activity?</b>	<b>Duration of the task per Week, Month, or Year</b>
<input type="radio"/> Metal work/grinding	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Varies	
<input type="radio"/> Chain saw/chipper	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Varies	
<input type="radio"/> Air Tools	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Varies	
<input type="radio"/> Farm implements	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Varies	
<input type="radio"/> Leaf Blower/Lawn mower	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Varies	
<input type="radio"/> Loud cars/boats/motorcycle/racing	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Varies	
<input type="radio"/> Aviation	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Varies	
<input type="radio"/> Music/concerts	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Varies	
<input type="radio"/> Music devices (e.g. iPod) If Yes, which ear is most affected? <input type="checkbox"/> Left Ear <input type="checkbox"/> Right Ear <input type="checkbox"/> Both		

**Additional comments:**

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\_\_\_\_\_

**Employee Signature:**

\_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/20\_\_\_\_

**\*\*\*ATTENTION SITE CONTACT\*\*\***

- This form may be emailed to [determinations@tkontheweb.com](mailto:determinations@tkontheweb.com)
- This form may be faxed to: 815.332.5175
- This form may be mailed to:

T K Group, Inc./1781 S. Bell School Rd..  
Rockford, IL 61016  
ATTN: Data Processing

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