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

Name:	
Company:	
Assessed Noise Exposure (TWA):	**Shift Duration:** ◯ 8 Hrs ◯ 12 Hrs

1. What type of hearing protectors do you use at work? ◯ None ◯ Foam Earplugs ◯ Ear Muffs ◯ Canal Caps ◯ 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?

◯ 0%-Never
◯ 5-20%-Rarely
◯ 25-50%-Occasionally
◯ 55-75%-Most of the time
◯ 80-95%-Often
◯ 100%-Always

4. Do you *currently* have any of the following ear related complaints?

◯ Ear Pain ▫ Left Ear ▫ Right Ear
◯ Ear Drainage ▫ Left Ear ▫ Right Ear
◯ Feeling Of Fullness ▫ Left Ear ▫ Right Ear
◯ Sudden Hearing Loss ▫ Left Ear ▫ Right Ear
◯ Severe Ringing In The Ear (s) ▫ Left Ear ▫ Right Ear

5. Have you been diagnosed by a physician with any of the following?

◯ Kidney Disease
◯ Viral Infection
◯ Meniere's Disease
◯ Vestibular Disorder
◯ Schwannoma/Acoustic Neuroma ▫ Left Ear ▫ Right Ear
◯ Otosclerosis ▫ Left Ear ▫ Right Ear
◯ Cholesteatoma ▫ Left Ear ▫ Right Ear
◯ Cancer/Chemotherapy/Radiation
◯ Severe Allergies
◯ Frequent Ear Wax Impaction ▫ Left Ear ▫ Right Ear
◯ Ear Injury/Perforated Eardrum ▫ Left Ear ▫ Right Ear
◯ Head Injury/Concussion

6. Do you work with any of the following chemicals? ◯ Toluene ◯ Xylene ◯ Styrene ◯ Methyl Ethyl Ketone (MEK)

7. Do you work in noise coming from one side? ◯ No ◯ Yes; If Yes, which ear is most affected? ▫ Left Ear ▫ Right Ear

8. Do you wear a shoulder mounted radio? ◯ No ◯ Yes; If Yes, which position of the speaker best applies?
▫ Closer to Left Ear ▫ Closer to Right Ear ▫ Positioned on Center of chest

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9. Have you been exposed to a work related blast? ◯ No ◯ Yes; If Yes which ear was most affected? ▫ Left Ear ▫ Right Ear

10. Do you work a noisy second job? ◯ No ◯ Yes

11. Have you served in the military? ◯ No ◯ Yes If Yes, Dates of service_____Branch_____
Were you noise exposed? ◯ No ◯ Yes
Did you wear hearing protection? ◯ No ◯ Yes

12. Do you discharge firearms? ◯ No ◯ Yes If Yes, what type(s)? _____
If Yes, how many rounds a year?_____If Yes, what type of shooting? ◯ Hunting ◯ Target ◯ Both
If Yes, do you wear hearing protection? ◯ No ◯ Yes ◯ Varies

13. Are you left or right handed? ◯ Left ◯ Right

14. Off-the-job activities	**Do you use hearing protection when performing the activity?**	**Duration of the task per Week, Month, or Year**
◯ Metal work/grinding	◯ Yes ◯ No ◯ Varies	
◯ Chain saw/chipper	◯ Yes ◯ No ◯ Varies	
◯ Air Tools	◯ Yes ◯ No ◯ Varies	
◯ Farm implements	◯ Yes ◯ No ◯ Varies	
◯ Leaf Blower/Lawn mower	◯ Yes ◯ No ◯ Varies	
◯ Loud cars/boats/motorcycle/racing	◯ Yes ◯ No ◯ Varies	
◯ Aviation	◯ Yes ◯ No ◯ Varies	
◯ Music/concerts	◯ Yes ◯ No ◯ Varies	
◯ Music devices (e.g. iPod) **I**f Yes, which ear is most affected? ▫ Left Ear ▫ Right Ear ▫ Both		

Additional comments:

_____
_____
_____
_____
_____

Employee Signature:

_____

Date: _____/_____/20 _____

ATTENTION SITE CONTACT

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