HEARING LOSS QUESTIONNAIRE

Patient Name: ___________________________________ Account #: ______________
Date: ____

1. Occupational History (most recent employer first, even if retired)

EMPLOYER LOCATION	JOB DESCRIPTION	LENGTH OF EMPLOYMENT	NOISE EXPOSURE YES NO	EAR PROTECTORS YES NO

2. ☐ YES ☐ NO Military Service or Equivalent Service?
3. ☐ YES ☐ NO Were you exposed to this noise beyond your basic training?

   Job Description: ____

4. Have you ever been exposed to any of the following non-occupational noise sources?

YES	NO	
☐	☐	Snowmobiles - Motorcycles
☐	☐	Chainsaw
☐	☐	Power Tools – Small Engines
☐	☐	Firing Range
☐	☐	Farm or Heavy Equipment
☐	☐	Hunting, Trap, or Skeet Shooting
☐	☐	Loud Music
☐	☐	Racing
☐	☐	Other _________________________
☐	☐	Do you regularly wear ear protection during these activities?

5. Have you ever suffered from any of the following:

YES	NO		YES	NO	
☐	☐	Hearing Loss	☐	☐	Malaria
☐	☐	Ear Surgery	☐	☐	High Fever Disease
☐	☐	Ear Injury	☐	☐	Dizziness
☐	☐	Running Ears	☐	☐	Sever Blow to Head
☐	☐	Ringing Ears	☐	☐	Sudden Change in Hearing

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