ACCESS OMNICARE

AUDIOGRAM & OTOLOGIC MEDICAL HISTORY

Date: _____/_____/_______ Company Name: ____

First Name: ____________________ M. I. ____ Last Name: ________________________________
Social Security Number: ______/_______/_______ Sex: M F Birth Date: ______/______/______
Hire Date: _____/______/______ Shift: ______ Noise Exposure Level on Job: ________dB (avg)
Job Description: ______________________________________ Dept: ___________________________

Have you had a hearing test before? ❑ Yes ❑ No Last Test Date:_____________________
Have you been told you have hearing loss? ❑ Yes ❑ No
How many hours since your last loud exposure to noise?
More than - 14 hrs? 12hrs? 10hrs? 8hrs? 6hrs? 4hrs? 2hrs? 1hrs? ❑ No Exposure to Noise
How long was your exposure in the noise? ________________

		Which ear?
Have you seen a doctor for ear problem or ear pain?	❑ Yes ❑ No	❑ Left ❑ Right
Draining from the ear?	❑ Yes ❑ No	❑ Left ❑ Right
Have you been dizzy or had a loss of balance?	❑ Yes ❑ No	
Do you have severe or constant ringing noise in the ears?	❑ Yes ❑ No	❑ Left ❑ Right
Experience a sudden or rapid hearing loss?	❑ Yes ❑ No	❑ Left ❑ Right
Hearing loss that continues to come and go?	❑ Yes ❑ No	❑ Left ❑ Right
A feeling of fullness or discomfort in the ear?	❑ Yes ❑ No	❑ Left ❑ Right
An ear problem related to using hearing devices?	❑ Yes ❑ No	❑ Left ❑ Right
A recent prescribed drug? List: __________________________		
Do you have high blood pressure?	❑ Yes ❑ No	
Ever had ear surgery?	❑ Yes ❑ No	❑ Left ❑ Right
Recent unconsciousness or head injury?	❑ Yes ❑ No	
Do you wear a hearing aid?	❑ Yes ❑ No	❑ Left ❑ Right
Mumps (child, teen, adult)	❑ Yes ❑ No	
Scarlet Fever (child, teen, adult)	❑ Yes ❑ No	
Meningitis (child, teen, adult)	❑ Yes ❑ No	
Ear wax build up or foreign object in the ear canal?	❑ Yes ❑ No	❑ Left ❑ Right
Any current allergies or hay fever?	❑ Yes ❑ No	
Hearing loss in your family?	❑ Yes ❑ No	
Relationship? _________________________________		
Have you previously worked in a noisy job?	❑ Yes ❑ No	
I was not using hearing protection before this test?	❑ Yes ❑ No	
Current or recent head cold or sinus infection?	❑ Yes ❑ No	
Noisy hobbies : Hunting, shooting, motorcycles, etc?	❑ Yes ❑ No	
Exposed to noise in military service or duty?	❑ Yes ❑ No	
Listening to loud music or using head phone at louder levels?	❑ Yes ❑ No	

Patient Signature ____ **Date:** __________________

Test performed by: ____