Reading Hospital
Occupational Health Services
AUDIOMETRIC HISTORY

Name: _____ Date of Birth: _____

Employer: _____ Today's Date: _____

Do you wear hearing aids? ❑ Yes ❑ No Hearing Conservation Training completed? ❑ Yes ❑ No

INITIAL HISTORY	**Y or N**	**Comments**
Did you have ear infections during childhood? Which ear, How frequently?		
If you have ever had a hearing test, when, where, why?		
Ever had attacks or dizziness? Date of onset? How frequently?		
Ever had measles, mumps, or scarlet fever?		
Ever had a head injury? If unconscious, how long?		
Anyone in your family have hearing loss before age 50? Known cause?		
Anyone in your family have hearing loss after age 50? Known cause?		
If exposed to noise in military service, give dates & type of exposure.		
Do you use firearms now or in the past? Type? How often? Which shoulder?		
Do you hear noise in your ears? Since when? Describe (roar, crickets, etc)		
Ever work in a noisy job? What and how long? Ear protection used?		
Ever had ear surgery? Why?		
List previous jobs:		
Continue below, if Initial History		
ANNUAL HISTORY UPDATE	**Y or N**	Comments
Do you have any hearing problems?		
Do your ears hurt or drain?		
Do you have noise in your ears?		
Do you have dizziness?		
Do you have allergies or sinus problems?		
Have you had any injuries, illness, or operations since last test?		
Do you have a second job?		
Do you have any noisy hobbies?		
Do you have diabetes, arthritis, or other chronic disorders?		
Do you take any medication?		
Do you hunt, skeet or target shoot? How often?		
Do you use a tractor, power tools, chain saws, etc?		