Carle

Audiology Questionnaire

Name: _____ Clinic Number: _____

Birth Date: _____ Employer: _____

SSN: _____ Date of Employment: _____

Please answer the following questions:

Current Information:

	Please circle your response	
Hours since last exposure to loud noise:	Less than or equal to 14 hours	Greater than 14 hours
Job title: _____		
Shift:	1st Shift 2nd Shift	3rd Shift rotate shifts
Protector Type:	ear muffs ear plugs	ear muffs and ear plugs
Frequency of Protector Use:	not used used sometimes	usually used always used
Self Evaluation: Please rate your hearing-	very good good average	poor very poor unknown

Medical Criteria:

Have you recently experienced pain in either ear?	Yes	No	Right	Left	Both
Have you recently experienced a draining ear?	Yes	No	Right	Left	Both
Have you recently experienced dizziness?	Yes	No	Right	Left	Both
Have you recently experienced severe tinnitus (ringing)?	Yes	No	Right	Left	Both
Have you recently experienced sudden hearing loss?	Yes	No	Right	Left	Both
Have you recently experienced fluctuating hearing loss?	Yes	No	Right	Left	Both
Have you recently experienced ear fullness or discomfort?	Yes	No	Right	Left	Both
Have you recently experienced pain in either ear?	Yes	No	Right	Left	Both
Have you recently had problems wearing hearing protection?	Yes	No			

Medical History:

Have you ever served in the military?	Yes	No			
Have you ever been to an ear specialist?	Yes	No	Right	Left	Both
Have you ever had a severe head injury?	Yes	No	Right	Left	Both
Have you ever had ear surgery recommended or performed?	Yes	No			
Have you ever had kidney disease?	Yes	No			
Have you ever had scarlet fever?	Yes	No			
Have you ever had meningitis?	Yes	No			
Do you have diabetes?	Yes	No			
Do you have high blood pressure?	Yes	No			
Do you have an existing hearing problem?	Yes	No			
Do you have frequent ear infections?	Yes	No	Right	Left	Both
Do you currently use prescription or over-the-counter drugs?	Yes	No			
Are you currently suffering from a cold, flu or allergies?	Yes	No			
Do you shoot guns or hunt?	Yes	No			
Do you operate farm equipment?	Yes	No			
Do you participate in loud activities (music, motorcycle)?	Yes	No			
Do you operate chain saws or power tools?	Yes	No			
Does any of your immediate family have hearing problems?	Yes	No			
Do you wear a hearing aid?	Yes	No	Right	Left	Both

Comments:

Do you have any other comments on the health of your hearing? _____

_____

_____

_____

Examiner Only:

Subject has visible wax or object in ear	Yes	No
Subject should be referred	Yes	No

_____ _____

Examiner Date Subject Date