

**Hearing History Form**

Name \_\_\_\_\_

Employer \_\_\_\_\_

Kaiser # \_\_\_\_\_

Today's Date \_\_\_\_\_ Date of Original History \_\_\_\_\_

**A. Have you ever had? Yes    No**

1. A previous hearing test by an employer?
2. Ear surgery or severe ear infection?
3. A close relative with known hearing loss?
4. Severe dizziness?

**B. Have you ever been routinely exposed to very loud noise?**

1. In a previous job?
2. In your present job?
3. In the armed forces?
4. Other (guns, saws, motorcycles, lawnmowers, snowmobiles?)
5. Did you wear ear protection at a previous job?

**C. Do you now have?**

1. Ear drainage or ear pain?  
Right ear    Left ear    Both ears
2. A perforated eardrum?  
Right ear    Left ear    Both ears
3. Ringing in the ear?  
Right ear    Left ear    Both ears
4. **A known hearing loss?**  
**If yes, how did it start?**  
Unknown    Childhood    Gradual    Suddenly  
Right ear    Left ear    Both ears
5. A cold, sinus infection, or allergy symptoms?

**D. Do you wear hearing protection on the job?**

If yes, what type? \_\_\_\_\_

**E. How do you perceive your own hearing?** Good Fair Poor  
\_\_\_\_\_(days/hours)

Signature \_\_\_\_\_ Date \_\_\_\_\_

*(Attach audiogram)*