KAISER PERMANENTE

Kaiser On-the-Job®

HEARING TEST QUESTIONNAIRE

LAST NAME	FIRST	MIDDLE	MR#
EXAM DATE	BIRTHDATE	WORK PHONE	HOME PHONE
EMPLOYER		POSITION TITLE	

1. **Have you been exposed to loud noise in the past 14 hours?___No___Yes(If Yes, explain below)**

2. Are you having any problems hearing? ____No____Yes (if yes, explain below)

3. Have you had severe or constant ringing noise in your ears? ____No ____Yes
   If yes, which ear ____left ____right

4. Have you had ear surgery? ____No____Yes
   If yes, which ear ____left ____right

5. Have you ever had a hearing test? ____No____Yes (If yes, date of last test and place)

6. Do you work in an area with a lot of noise? ____No____Yes (if yes, explain below)

7. Have you ever worked in a noisy job other than this company? ____No___Yes (if yes, explain below)

8. Do you have any hobbies that create loud noise? ____No____Yes (if yes, explain below)

9. Do you have any allergies, have the flu or a cold? ? ____No____Yes (if yes, explain below)

10. Do you use hearing protection? ____ yes ____ no
    If yes, what type? ____ plugs ____muffs

11. Please list all current prescription and over the counter medications:

Patient Signature:_____ **Date:**_____

Hearing Technician Signature:_____**Date:**_____