WorkFitMedical
Occupational Health Services

Audiometric History Form

Patient Name: _____ DOB: _____

TYPE OF TEST:
☐ Pre-Placement ☐ Baseline (Initial) ☐ Annual ☐ Retest ☐ Termination ☐ Other: _____

EMPLOYEE HISTORY:
Job Title: _____ Department: _____ Shift: _____

Have You been exposed to noise within the last 14 hours? ☐ Yes ☐ No
If Yes, please explain: _____

How do you rate your hearing? ☐ Poor ☐ Average ☐ Good ☐ Very Good

How often do you wear hearing protection at work? ☐ Never ☐ Sometimes ☐ Usually ☐ Always
If Yes, what type of hearing protection do you wear? ☐ Earplugs ☐ Earmuffs ☐ Both

How often do you wear hearing protection at home? ☐ Never ☐ Sometimes ☐ Usually ☐ Always
If Yes, what type of hearing protection do you wear? ☐ Earplugs ☐ Earmuffs ☐ Both

RECREATIONAL ACTIVITIES/ADDITIONAL NOISE EXPOSURE

Activity	Yes	No	Activity	Yes	No
Hunting/Shooting	☐	☐	Military Service	☐	☐
Power Tool Use	☐	☐	Auto Racing	☐	☐
Farm Equipment Use	☐	☐	Motorcycle Use	☐	☐
Loud Music	☐	☐	Previous Job Exposure	☐	☐

MEDICAL HISTORY

Condition	Yes	No	Condition	Yes	No
Measles	☐	☐	Diabetes	☐	☐
Mumps	☐	☐	Meningitis	☐	☐
Ear Pain	☐	☐	Ear Infections	☐	☐
Severe Ringing	☐	☐	Dizziness	☐	☐
Hearing Loss	☐	☐	Wax/Foreign Body	☐	☐
Wear Hearing Aid(s)	☐	☐	Ear Surgery	☐	☐
Family History of Hearing Loss	☐	☐	Head Injury	☐	☐
Recent Head Cold/URI	☐	☐	Chemotherapy	☐	☐

Employee Signature: _____ Date: _____

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