Washington Health System Occupational Medicine
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AUDIOLOGICAL EXAM HISTORY

Name: _____ Birthdate: _____

Company: _____ Occupation: _____

To be completed by Patient:

Ear-related symptoms:	Yes	No	Right	Left	Both	Patient Comment(s)
Have you recently experienced **PAIN** in either ear?.....	*	*	*	*	*	
Have you recently experienced a **DRAINING** ear?.....	*	*	*	*	*	
Have you recently experienced **DIZZINESS**?.....	*	*	*	*	*	
Have you recently experienced severe **TINNITUS** (ringing)?.....	*	*	*	*	*	
Have you recently experienced **sudden HEARING LOSS**?.....	*	*	*	*	*	
Have you recently experienced **fluctuating HEARING LOSS**?.....	*	*	*	*	*	
Have you recently experienced ear **FULLNESS / DISCOMFORT**?	*	*	*	*	*	
Have you recently had problems wearing hearing protection?.....	*	*				

Ear-related Medical History:	Yes	No	Right	Left	Both	Patient Comment(s)
Have you ever been to a doctor for an **ear-related problem**?.....	*	*	*	*	*	
Have you ever had **ear surgery**?.....	*	*	*	*	*	
Have you ever had an **ear injury**?.....	*	*	*	*	*	
Do you have frequent **ear infections**?.....	*	*	*	*	*	
Do you wear a **hearing aid**?.....	*	*	*	*	*	
Do you have an **existing hearing problem**?.....	*	*	*	*	*	
Does any of your immediate family have hearing problems?.....	*	*				

General Medical History:	Yes	No	Patient Comment(s)
Have you ever had kidney disease, diabetes, high blood pressure?..	*	*	
Have you ever had measles, mumps, scarlet fever, or meningitis?...	*	*	
Do you currently use prescription or over the counter drugs?.....	*	*	
Have you ever had a severe head injury?.....	*	*	
Are you currently suffering from allergies?.....	*	*	

Personal History:	Yes	No	Patient Comment(s)
Have you ever served in the military?.....	*	*	
Do you shoot guns or hunt?.....	*	*	
Do you participate in loud activities at home (music, power tools, cars, motorcycles, etc.)?.....	*	*	

Occupational History:	Yes	No	Patient Comment(s)
Are you exposed to noise at your job?.....	*	*	
If yes, do you wear hearing protection as instructed?.....	*	*	
Have you been exposed to noise within the past 14 hours?.....	*	*	
If yes, were you wearing hearing protection?	*	*	

Surveillance Questions:			Patient Comment(s)

When was your last hearing test?_____

Was it normal?..... ☐ Yes ☐ No

Do you have any other comments on the health of your hearing? ☐ Yes ☐ No If Yes, please explain:

Patient Signature: _____ Date: _____ Time: _____

Technician Signature: _____ Date: _____ Time: _____

Provider Signature: _____ Date: _____ Time: _____