Patient Name:_____ Date of Birth:_____

	No	Yes	If YES, please explain
1. Do you have now or have you ever had: Difficulty hearing?			
Ringing or Buzzing in ears?			
Dizziness?			
Eardrum Perforation?			
Ear Surgery?			
Severe ear Infection or Viral Illness?			
Pain in the ear?			
2. Have you heard loud, constant noise or music within the last 14 hours?			
3. Have you heard loud, sudden noise in the past 14 hours?			
4. Do you wear hearing aid(s)? If so, specify ear(s) □ Right Ear □ Left Ear			
5. Are you in a Hearing Conservation Program?			
6. Do you use hearing protection equipment?			
7. Are you exposed to loud noises on your present job?			
8. Do you wear hearing protectors? What type? □ Plugs □ Muff □ Both Together			
9. Was you hearing previously tested? If YES, result if known:			
10. Did you wear hearing protection today prior to today's test?			
11. Do you have a head cold or sinus condition today?			
12. Do you use chain saws, power tools, ets.?			
13. Do you shoot guns, long guns, or pistols?			
14. Are you exposed to organic solvents, heavy metals or other chemicals? If YES, list chemicals:			

OTOSCOPIC EXAM

Date: _____

	Right		Left	
	Yes	No	Yes	No
Is eardrum visible?				
Is perforation present?				
Is eardrum normal?				
Other findings?				

Document Other Findings:

_____
_____
_____
_____

I hereby certify that the foregoing information is complete and correct to the best of my knowledge. I understand that the results of my hearing test will be shared with the company/agency requesting exam.

X_____ _____
Patient Signature **Date**

_____
Examiner's Name (Please Print)

_____ _____
Examiner's Signature Date

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