Atrium Health

Audiometry Questionnaire

Name (first)_____(last) _____

Gender _____ Date of Birth _____

Shift _____ Date of Hire _____

Company Name _____Department_____

Job Description _____

Have you had:

	Yes	No
1) Hearing loss in family?		
2) Dizziness/balance problem?		
3) Persistent ringing in one or both ears?		
4) Recent earache?		
5) Recent drainage from one or both ears?		
6) Sudden hearing change?		
7) Fluctuating hearing?		
8) Fullness/discomfort in one or both ears?		
9) Visible ear wax accumulation?		
10) Prescription drug use?		
11) Elevated Blood Pressure?		
12) Diabetes?		
13) Arthritis?		
14) Recent doctor visit for ears?		
15) Ear surgery?		
16) Head trauma?		
17) Measles, mumps?		
18) Meningitis, scarlet fever?		

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Scan document into Canopy-> Document type "Workers Comp/Occ Med"-> Subject line "Audiometry Questionnaire"

19) Kidney disease?		
20) Chronic allergies, URIs?		
21) Military service?		
22) Car races, hunting, target shooting?		
23) Recent cold?		
24) Loud music or power tools? (non work-related)		
25) Exposure to any loud noise? (non work-related)		
26) Do you always wear hearing protection on the job?		

Attestation Statement:

Employee ONLY:

Please sign below certifying that your answers to the questionnaire are complete to the best of your knowledge and that you understand the questions and information asked of you throughout the questionnaire:

_____

Employee's printed name

_____

Employee's signature *Date*

Licensed Medical Provider ONLY:

I have reviewed the above questionnaire in its entirety and provided feedback to the patient.

_____

Provider's printed name

_____

Provider's signature *Date*