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AUDIOGRAM WORKSHEET

Patient Information

Employee Name (Please PRINT) _____

Your Physician _____

Birthdate ____/____/____ Your Phone Number () _____ ID or Last 4 Digits S.S. **XXX/XX/** _____

Company _____ Position _____

How long have you been at this present job? ____ Year ____ Months ____/____/____ Date Hired _____

Please check the box(es) below if you have ever had:

<input type="checkbox"/> Earaches	<input type="checkbox"/> Ear disease(s)	<input type="checkbox"/> Frequent build up of ear wax	<input type="checkbox"/> Head injury with unconsciousness
<input type="checkbox"/> Ear infections	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Ear surgery	<input type="checkbox"/> Childhood illness with high fever
<input type="checkbox"/> Severe dizziness	<input type="checkbox"/> Frequent cold	<input type="checkbox"/> Sinus condition	
<input type="checkbox"/> Perforated eardrum	<input type="checkbox"/> Allergies	<input type="checkbox"/> Hearing loss in family before age 50	

Are you aware of any hearing loss? ____ No ____ Yes ____ Both ears ____ Left ____ Right

Have you had this medically evaluated? ____ No ____ Yes What caused your hearing loss? _____

Did the loss occur: ____ Gradually ____ Suddenly ____ Recently ____ In childhood ____ Unknown

Were you exposed to noise in the military service? ____ No ____ Yes Type _____ Dates _____

Please list your occupational history, starting with the most recent:

	Type of Work	Company	Noise Exposure	Ear Protectors	Duration of employment in noise
1.			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2.			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3.			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Are you routinely exposed to noise in your present job? ____ Yes ____ No

Percent of time on the job exposed to noise 10 20 30 40 50 60 70 80 90 100

Describe the noise: __ Continuous/steady __ Impulsive (shot-like) __ Intermittent __ Combination of each

Do you wear hearing protection on the job? __ Yes __ No If YES; __ Plugs __ Muffs __ Other

How many years have you worked in noise? __ 0-5 years __ 5-10 years __ 10 years or more

Indicate if you are exposed to any of the following off-the-job noises?

- | | | | |
|--|-------------------------------------|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Chain Saws | <input type="checkbox"/> Lawnmowers | <input type="checkbox"/> Motorcycles | <input type="checkbox"/> Tractors |
| <input type="checkbox"/> Rock band music | <input type="checkbox"/> Firearms | <input type="checkbox"/> Power tools | <input type="checkbox"/> None |

Do you wear hearing protection off the job? Yes No

How long has it been since your last noise exposure?

<input type="checkbox"/> 0-30 minutes	<input type="checkbox"/> 30-60 minutes	<input type="checkbox"/> 1-2 hours
<input type="checkbox"/> 2-5 hours	<input type="checkbox"/> 5-8 hours	<input type="checkbox"/> More than 14 hours

Employee Signature

Date