Employee Aural History Form

Last Name	First Name	SS#	Today's Date

Military Service: Which Branch?		How many years?
Where you exposed to gunfire of noise:	☐Yes ☐No	
Did you wear ear protection?	☐Yes ☐No	If yes: ☐Plugs ☐Muffs ☐Both

Employer:	**Exposed To Noise**	**Hearing Protection**
Present:	☐Yes ☐No	☐Plugs ☐Muffs ☐Both
Past:	☐Yes ☐No	☐Plugs ☐Muffs ☐Both

Hobbies:		
Check if you have ever had any of these hobbies. Check if you used hearing protection		
☐Race Cars or Motorcycles	☐Yes ☐No	☐Plugs ☐Muffs ☐Both
☐Loud Music	☐Yes ☐No	☐Plugs ☐Muffs ☐Both
☐Saws or Loud Equipment	☐Yes ☐No	☐Plugs ☐Muffs ☐Both
☐Use of Firearms	☐Yes ☐No	☐Plugs ☐Muffs ☐Both
☐Hunt /Target Shoot	☐Yes ☐No	☐Plugs ☐Muffs ☐Both
☐Other noisy hobbies:	☐Yes ☐No	☐Plugs ☐Muffs ☐Both

Medical History:	Have you had or currently have any of the following?	
1.	Family history of hearing loss	☐Yes ☐No
2.	Measles	☐Yes ☐No
3.	Current cold or sinus problem	☐Yes ☐No
4.	Frequent ear aches	☐Yes ☐No
5.	Dizziness	☐Yes ☐No
6.	Ringing in the ears	☐Yes ☐No
7.	Temporary hearing loss	☐Yes ☐No
8.	Head injury requiring hospitalization	☐Yes ☐No
9.	Ever taken antibiotics for long periods	☐Yes ☐No
10.	Had ear surgery or seen by an ear doctor	☐Yes ☐No
11.	Do you wear a hearing aid:	☐Yes ☐No Which ear?
Comments for any positive answer:____________________		
____________________		
____________________		

For Staff Use Only

History Update: Write today's date and check below if the patient has experienced any of the following since their last hearing test. If not, check no change.

Date	Earaches	Ear or head injury	Major surgery	Dizziness	Ringing In ears	New noisy hobbies	No Change