

COMPANY CARE AUDIOGRAM REPORT

Name: _____ Age _____ Date of Birth _____ Social Sec. # _____ - _____ - _____

Reason for Test: Pre-Employment Baseline Periodic Retest Employer: _____

Please Answer Questions Below:

- | YES | NO | |
|-----------------------|-----------------------|---|
| <input type="radio"/> | <input type="radio"/> | Does anyone in your family have a hearing loss? If yes, who? _____ |
| <input type="radio"/> | <input type="radio"/> | Do you now or have you ever had hearing trouble? |
| <input type="radio"/> | <input type="radio"/> | Do you now or have you ever worn or been advised to wear hearing aids? |
| <input type="radio"/> | <input type="radio"/> | Have you ever had your hearing tested? If yes, when and where? _____ |
| <input type="radio"/> | <input type="radio"/> | Have you ever had any ear infection? If yes, which ear? _____ |
| <input type="radio"/> | <input type="radio"/> | Have you ever been exposed to gunfire? |
| <input type="radio"/> | <input type="radio"/> | Do you hunt using firearms? |
| <input type="radio"/> | <input type="radio"/> | Have you ever been in the military? |
| <input type="radio"/> | <input type="radio"/> | Do you ride a motorcycle? |
| <input type="radio"/> | <input type="radio"/> | Any other noisy habits? If yes, explain _____ |
| <input type="radio"/> | <input type="radio"/> | Have you ever had surgery on either ear? If yes, which ear? _____ |
| <input type="radio"/> | <input type="radio"/> | Have you ever worked at a noisy job? Where? _____ |
| <input type="radio"/> | <input type="radio"/> | Do you have a second job? |
| <input type="radio"/> | <input type="radio"/> | Have you ever had drainage from your ears? If yes, which ear? _____ |
| <input type="radio"/> | <input type="radio"/> | Are you taking or have you taken drugs, antibiotics or medications regularly? |
| <input type="radio"/> | <input type="radio"/> | Have you ever had dizziness? If yes, explain: _____ |
| <input type="radio"/> | <input type="radio"/> | Have you ever had noises in your ears? If yes, explain: _____ |
| <input type="radio"/> | <input type="radio"/> | Have you ever had measles, mumps or scarlet fever? If yes, when _____ |
| <input type="radio"/> | <input type="radio"/> | Do you currently have a cold? |
| <input type="radio"/> | <input type="radio"/> | Have you been exposed to loud noises in the past 14 hours? If yes, was hearing protection worn? _____ |

To the best of my knowledge, the above information is true and complete. Date: _____ Individuals Signature: _____

Clinical Staff to Complete

Tester: _____ Audiometer: MAICO MA 800 Series II Calibration Date: _____

	LEFT EAR						RIGHT EAR							
	500	1K	2K	3K	4K	6K	8K	500	1K	2K	3K	4K	6K	8K
Base	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Test 1	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Test 2	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

Otoscopic Screening:
 Right Ear Appears Normal Blockage of wax or foreign body that prevents view of the eardrum Other: _____
 Left Ear Appears Normal Blockage of wax or foreign body that prevents view of the eardrum Other: _____