SARATOGA HOSPITAL
MEDICAL GROUP
OCCUPATIONAL MEDICINE
2388 ROUTE 9 • MECHANICVILLE • NY • 12118
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DOB: Age: Sex:
ADM/SVC Date: Arrival Time:
Loc:

MR#:

Audiologic Questionnaire

Name: _____

1. Have you been exposed to noise in the last 14 hours at work or home? ☐ Yes ☐ No
   If yes, please explain: _____ Did you wear hearing protection? ☐ Yes ☐ No
2. Do you wear hearing protection at work?
   ☐ Always ☐ Usually ☐ 1/2 time ☐ Sometimes ☐ Seldom ☐ Not used
   When you wear hearing protection, which type do you wear? ☐ Ear plugs ☐ Canal caps ☐ Ear muffs
   If you do NOT wear hearing protection, Why? _____
3. What kind of hearing protection do you use outside work? ☐ Ear plugs ☐ Canal caps ☐ Ear muffs ☐ None
4. How long have you worked for your present company? _____ Years _____Months
5. Were you ever exposed to noise while employed at another company? ☐ Yes ☐ No
   If Yes, Name: _____ Dates worked there: _____
6. Were you in the military? ☐ Yes ☐ No
7. Have you frequently participated in any of the following activities?
   ☐ Snowmobiling ☐ Motorcycles ☐ Guns (hunt or target)
   ☐ Listening to loud music ☐ Power tools (at home) ☐ None of these
8. Has anything ever exploded near your ear? ☐ No ☐ Yes If yes, which ear? ☐ Right ☐ Left
9. Do you presently have a cold? ☐ Yes ☐ No
10. Do you experience ringing, buzzing, or hissing in your ear(s)? ☐ Yes ☐ No
11. Do you feel you have hearing loss? ☐ Yes ☐ No
12. How would you rate your hearing? ☐ Good ☐ Poor
13. In which ear do you feel you hear better? ☐ Right ☐ Left ☐ Both the same
14. Do you presently or have you ever used a hearing aid? ☐ Yes ☐ No
15. Does anyone in your family have hearing loss? ☐ Yes ☐ No
16. Do you currently or have you in the past taken the following prescription or over the counter medications?
    ☐ Aspirin, Bufferin, Excedrin (more than 6 per day) ☐ Neomycin ☐ Streptomycin ☐ Gentamicin ☐ Quinine
17. Check any of the following you have had:

☐ Hearing loss	☐ Tonsillitis	☐ Kidney infection
☐ Treatment for ear trouble	☐ Sinus problems	☐ Diabetes
☐ Earaches	☐ Mumps, Measles, Scarlet Fever,	☐ Encephalitis
☐ Ear drainage	Whooping Cough, Diphtheria	☐ Elevated blood pressure
☐ Perforated ear drum	☐ Meningitis	☐ Frequent headache
☐ Head injury	☐ Tuberculosis	☐ High fever
☐ Dizziness		☐ Allergies

If you checked any of the above, please explain: _____

_____

_____

Patient Signature: _____ Date/Time: ____/____

Examiner Print Name: _____ Examiner Signature: _____ Date/Time: ____/____