



Date _____
Month Day Year

Name: _____ SS#: _____

Employer: _____

Please complete the following Hearing Conservation Program questions:

- A. Were you trained at the time that you started your employment to wear hearing protection devices? Yes/No
- B. Have you been educated when and where to wear hearing protection devices? Yes/No
- C. Did you wear hearing protection devices prior to today's test if you were in a noise hazard environment? Yes/No/NA
- D. Have you ever had ringing in the ears? Yes/No
- E. Ruptured ear drum? Yes/No
- F. Do you have high blood pressure? Yes/No
- G. Loss or change of hearing? Yes/No
- H. See a doctor for ear problems? Yes/No
- I. Had ear, head or neck injury? Yes/No
- J. Been unconscious from a head injury? Yes/No
- K. Wear hearing aids? Yes/No
- L. Experienced any of the following (please circle)?
Mumps, scarlet fever, measles, meningitis, diabetes, kidney disease, allergies/hay fever
- M. Hearing loss in family? Yes/No
- N. Have a head cold today? Yes/No
- O. Noisy hobbies? Yes/No
- P. Loud music/headphones? Yes/No
- Q. Previous job with loud noise exposure? Yes/No
- R. Trouble with hearing loss? Yes/No
- S. Have you ever been evaluated by a hearing specialist? Yes/No

Please explain 'yes' responses to questions D-S:

Please do not write below this line.

Medical provider comments on medical history:

Provider

Date