EMPLOYEE INFORMATION FORM FOR HEARING TESTS

First Name_____Middle Initial _____Last Name_____

Date of Birth _____/_____/_____ Clock or Identifying # _____
Month Day Year

_____ _____ _____
Department Job Title Shift

Do you have any problems with your ears that we should be aware of? Yes ( ) No ( )
If yes, please explain:

_____

_____

Have you seen an ear doctor or an audiologist for above problem? Yes ( ) No ( )

Do you wear a hearing aid? Yes ( ) No ( )
Do you have a cold today? Yes ( ) No ( )
Do you have ringing in your ears? Yes ( ) No ( )

While you are exposed to high noise, how often do you wear hearing protection?
Always ( ) Usually ( ) Occasionally ( ) Never ( )

If so, what kind?
Plugs ( ) Muffs ( ) Plugs & Muffs at the same time ( ) Semi-Inset/Canal Cap ( )

I am never exposed to loud noise so I don't need hearing protection ( )

If you have been exposed to loud noise within the past 14 hours have you worn hearing protection? Yes ( ) No ( )