



**UNIVERSITY OF  
CALGARY**

# Audiometric Testing Questionnaire

Send completed form to confidential fax # 403-282-8603

## Staff Wellness

### PERSONAL AND CONTACT INFORMATION

Name:		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	DOB (mm/dd/yy):
Employee ID#:	Email:	Phone #:	
Job Title:	Worksite Location:	Department:	
Supervisor:	Email:	Phone #:	

### PART A: EMPLOYEE TO COMPLETE

Indicate if you have ever had any of the following:	Additional Questions (please check all that apply)
Ear pain: <input type="checkbox"/> Left <input type="checkbox"/> Right Use of Hearing Aid: <input type="checkbox"/> Left <input type="checkbox"/> Right Sudden Hearing Loss: <input type="checkbox"/> Left <input type="checkbox"/> Right Feel Fullness in Ear: <input type="checkbox"/> Left <input type="checkbox"/> Right Ear Surgery: <input type="checkbox"/> Left <input type="checkbox"/> Right Draining Ear: <input type="checkbox"/> Left <input type="checkbox"/> Right Hearing Protector Problem: <input type="checkbox"/> Left <input type="checkbox"/> Right Known Excessive Wax: <input type="checkbox"/> Left <input type="checkbox"/> Right Ear infection: <input type="checkbox"/> Left <input type="checkbox"/> Right  Ringing in Ears: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe  Seen Doctor for Ear Problem: <input type="checkbox"/> Left <input type="checkbox"/> Right Fluctuating Hearing Loss: <input type="checkbox"/> Left <input type="checkbox"/> Right  <input type="checkbox"/> Head Injury/unconsciousness	<input type="checkbox"/> Experienced dizziness Explain: <input type="checkbox"/> Use prescription medications Please list: <input type="checkbox"/> Family history of hearing loss Explain: <input type="checkbox"/> Served in the military Years/Guns?: Use guns: Trigger hand: <input type="checkbox"/> Left <input type="checkbox"/> Right Kind/how often: Work with chemicals? <input type="checkbox"/> Yes <input type="checkbox"/> No Kind: <input type="checkbox"/> Carbon Monoxide <input type="checkbox"/> Lead <input type="checkbox"/> Manganese <input type="checkbox"/> Styrene <input type="checkbox"/> Toluene <input type="checkbox"/> Xylene <input type="checkbox"/> Other: How often: <input type="checkbox"/> Exposed to noise when off the job (loud music, vehicles/equipment/tools (e.g. motorcycle, snowmobile, chainsaw)) Kind/how often:
Have you had: <input type="checkbox"/> Mumps <input type="checkbox"/> Meningitis <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Measles <input type="checkbox"/> Diabetes <input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Hearing protection worn in noisy environment Kind/how often:
Were you exposed to noise in the past 14 hours? <input type="checkbox"/> No <input type="checkbox"/> Yes - was protection worn? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Changes in hearing Explain:
Are you experiencing any of the following today? <input type="checkbox"/> Allergies <input type="checkbox"/> Head Cold <input type="checkbox"/> Flu	Smoking history: <input type="checkbox"/> Never <input type="checkbox"/> Quit <input type="checkbox"/> Current Comment:
Have you had a hearing test before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when?	
Employee signature of accuracy of completion: X	Testing Date:

### PART B: EXAMINER TO COMPLETE

<b>Otoscopic Results</b> Left Ear: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Excess Wax <input type="checkbox"/> Blockage <input type="checkbox"/> Perforation Right Ear: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Excess Wax <input type="checkbox"/> Blockage <input type="checkbox"/> Perforation		
Comments: <input type="checkbox"/> Results discussed with examinee <input type="checkbox"/> Examinee counseled on hearing conservation		
Examiner Name:	Signature: X	Exam Date: