



# Medical Department Audiometric History

Form 9843 - X

(Check One)

- Baseline       Annual/Periodic

Test Date / /	Time
Audiometer (Model and Serial Number)	Calib. Date
Testing Company/Examiner's Name	
OSHA Sound Room Requirements Met? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>(Staple audiogram here)</b>	

	Left	Right	Otoscopic Exam
500			L      R
1000			<input type="checkbox"/> Was not done <input type="checkbox"/>
2000			<input type="checkbox"/> Normal <input type="checkbox"/>
3000			<input type="checkbox"/> Abnormal <input type="checkbox"/>
4000			<input type="checkbox"/> Blockage <input type="checkbox"/>
6000			<input type="checkbox"/> Disease <input type="checkbox"/>
8000			<input type="checkbox"/> Obstruction <input type="checkbox"/>
			<input type="checkbox"/> Perforation <input type="checkbox"/>
			<input type="checkbox"/> Surgery/Scarring <input type="checkbox"/>
			<input type="checkbox"/> Excess Earwax <input type="checkbox"/>

Other Comments

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## Employee Information

- Please Print -

Name (Last, First, Middle Initial)		<b>If Labels Used Place Here</b>
Employee Number	Social Security Number	
Birthdate / /	Job Title	
Dept. Number	Loc. Code	Hire Date / /
<b>Please fill in shaded areas</b>		
Shift Number	Shift Length	Sex <input type="checkbox"/> M <input type="checkbox"/> F
<b>27</b> Are you an operator of a Powered Industrial Vehicle/Personnel Lift/Burden Carrier (forklift, hoist, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Was Hearing Protection Worn Prior to Test <input type="checkbox"/> Yes <input type="checkbox"/> No	Noise Exposure    dBA/8 hr. TWA	

## Complete this section for **FIRST TEST ONLY**

### Initial Case History Information

(Check **ALL** that apply and indicate ear)

Indicate Ear

- |  |   |
|--|---|
| 25 <input type="checkbox"/> Known hearing loss               | <input type="checkbox"/> L <input type="checkbox"/> R |
| 20 <input type="checkbox"/> Saw Dr. for ear problems         | <input type="checkbox"/> L <input type="checkbox"/> R |
| 21 <input type="checkbox"/> Ear surgery                      | <input type="checkbox"/> L <input type="checkbox"/> R |
| 23 <input type="checkbox"/> Used a hearing aid               | <input type="checkbox"/> L <input type="checkbox"/> R |
| 24 <input type="checkbox"/> Have had mumps                   |   |
| 22 <input type="checkbox"/> Head injury / unconsciousness    |   |
| 18 <input type="checkbox"/> Use of - mycin antibiotics       |   |
| 19 <input type="checkbox"/> High blood pressure              |   |
| 28 <input type="checkbox"/> Diabetes                         |   |
| 29 <input type="checkbox"/> Kidney disease                   |   |
| 32 <input type="checkbox"/> Family members with hearing loss |   |

### Past noise exposure:

- 36  Been in the military
- 34  Worked in noisy job previously
- 37  Noisy hobbies (check):     loud engines,     power tools,  
Other (list) \_\_\_\_\_
- 39  Firearms
- 38  List type of hearing protection used with noisy hobbies \_\_\_\_\_

Please explain any checked responses. (Include dates)

## Complete this section for **ALL** hearing tests - Annual Case History Update (Check **ALL** that apply and indicate ear)

Please evaluate your hearing at this time. (Check One)

- Excellent     Good     Fair     Poor

Within the past 12 months:

Indicate Ear

- |   |   |
|---|---|
| 10 <input type="checkbox"/> Ear pain  | <input type="checkbox"/> L <input type="checkbox"/> R |
| 11 <input type="checkbox"/> Ear drainage  | <input type="checkbox"/> L <input type="checkbox"/> R |
| 13 <input type="checkbox"/> Severe ringing in ears  | <input type="checkbox"/> L <input type="checkbox"/> R |
| 14 <input type="checkbox"/> Sudden hearing loss   | <input type="checkbox"/> L <input type="checkbox"/> R |
| 15 <input type="checkbox"/> Fluctuating hearing loss  | <input type="checkbox"/> L <input type="checkbox"/> R |
| 16 <input type="checkbox"/> Feeling of fullness in ears   | <input type="checkbox"/> L <input type="checkbox"/> R |
| 17 <input type="checkbox"/> Ear problems when using hearing protection devices  | <input type="checkbox"/> L <input type="checkbox"/> R |
| 30 <input type="checkbox"/> Excessive ear wax buildup   | <input type="checkbox"/> L <input type="checkbox"/> R |
| 20 <input type="checkbox"/> Saw doctor for ears since last test   | <input type="checkbox"/> L <input type="checkbox"/> R |
| 25 <input type="checkbox"/> Known hearing loss  | <input type="checkbox"/> L <input type="checkbox"/> R |
| 23 <input type="checkbox"/> Used a hearing aid  | <input type="checkbox"/> L <input type="checkbox"/> R |
| 12 <input type="checkbox"/> Dizziness   |   |
| 37 <input type="checkbox"/> Noisy hobbies (check): <input type="checkbox"/> loud engines, <input type="checkbox"/> power tools,<br>Other (list) _____ |   |
| 39 <input type="checkbox"/> Firearms  |   |

- 38  List type of hearing protection used with noisy hobbies \_\_\_\_\_
- 35  Have head cold / sinus / allergy problem Today?
- 33  In high noise without hearing protection prior to today's hearing test?
- 31  Have had previous 3M hearing tests.

**3M location of previous test:** \_\_\_\_\_

### Type of hearing protection used

- Plugs
- Muffs
- Plug & Muff
- Either Plug or Muff

Please explain any checked responses. (Include dates)

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**This information is true to the best of knowledge.** →

Employee Signature

Date

/ /