Champlain Valley
Urgent Care
and Occupational Health
Phone: 802-865-3655

LAST NAME: _____ FIRST: _____ DATE OF BIRTH: _____

SOCIAL SECURITY #: _____ SEX: _____ COMPANY: _____

CUMULATIVE AUDIOMETRIC RECORD

Date	Time	Otoscopic* Right	Otoscopic* Left	Audiometer Model and Serial Number	Last Annual Calibration Date	Hours Since Exposure	Thresholds in dB HTL — RIGHT EAR 500 HZ	RIGHT EAR 1000 HZ	RIGHT EAR 2000 HZ	RIGHT EAR 3000 HZ	RIGHT EAR 4000 HZ	RIGHT EAR 6000 HZ	RIGHT EAR 8000 HZ	LEFT EAR 500 HZ	LEFT EAR 1000 HZ	LEFT EAR 2000 HZ	LEFT EAR 3000 HZ	LEFT EAR 4000 HZ	LEFT EAR 6000 HZ	LEFT EAR 8000 HZ	Muffs, Plugs, Semi-inserts	Tech Cert #	Test Location	Comments

***Otoscopic Exam:**
- **N: Normal**
- **W: Wax**
- **D: Draining ear**
- **S: Narrow Canal**

EMPLOYEE HISTORY: Name: _____ Date: _____

Military Service: When: _____ Branch: _____

Exposed to gunfire or noise? ❑ Yes ❑ No

Did you wear hearing protection? ❑ Yes ❑ No

Occupational History: List your present employment and any other noisy jobs you have had.

Employer	Exposed to Noise? YES	Exposed to Noise? NO	Hearing protection worn? YES	Hearing protection worn? NO
_____	❑	❑	❑	❑
_____	❑	❑	❑	❑
_____	❑	❑	❑	❑

Hobbies: Please indicate if you have ever participated in these hobbies, and if you have used hearing protection

	YES	NO	Hearing Protection		YES	NO	Hearing Protection
Drive Motorcycle	❑	❑	❑	Use stereo headphones	❑	❑	❑
Race Cars	❑	❑	❑	Play a musical instrument/rock band	❑	❑	❑
Hunt or use firearms	❑	❑	❑	Use chain saw or other power tools	❑	❑	❑

Other noisy hobbies not listed: _____

Medical History: Have you had or do you currently have any of the following:

	YES	NO		YES	NO
Family history of hearing loss	❑	❑	Dizziness	❑	❑
Measles	❑	❑	Temporary hearing loss	❑	❑
Mumps	❑	❑	Ringing in the ears	❑	❑
Head injury	❑	❑	Do you wear a hearing aid	❑	❑
Frequent headaches	❑	❑	Which ear? ____ For how long? _____		
Ever taken antibiotics for a long period of time?	❑	❑	What antibiotic? _____		
Ever been to an ear doctor?	❑	❑	For what? _____		
Had ear surgery?	❑	❑	For what? _____		
Ever had your hearing tested before	❑	❑	When? _____ Where? _____		

History Update: Write in today's date and indicate below if you have experienced any of the following since your last test. If not, check "no change."

Date:	Earaches	Ear or head injury	Major surgery	Dizziness	Ringing in ears	New hobby	No change
	❑	❑	❑	❑	❑	❑	❑
	❑	❑	❑	❑	❑	❑	❑
	❑	❑	❑	❑	❑	❑	❑
	❑	❑	❑	❑	❑	❑	❑
	❑	❑	❑	❑	❑	❑	❑
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	❑	❑	❑	❑	❑	❑	❑
	❑	❑	❑	❑	❑	❑	❑
	❑	❑	❑	❑	❑	❑	❑
	❑	❑	❑	❑	❑	❑	❑