AUDIOGRAM QUESTIONNAIRE

PATIENT NAME_____ SS#_____

Do you presently, or have you ever had any ear problems or difficulty hearing?
_____Yes _____No

If yes, please explain_____

Does anyone in your immediate family (parents, siblings) have any hearing difficulties? _____Yes _____No

If yes, please explain_____

Have you ever been exposed to the noise of gunfire military/non-military such as: basic military training, war time, target/sport shooting)? _____Yes _____No

If yes, please explain (please include what type of gunfire and estimated exposure time)_____

Have you ever worked in a noisy environment in any of your previous employment? _____Yes _____No

If yes, please explain_____

Normal days/hours worked_____

Type of work performed_____

Do you perform part-time or full-time work for any employer (including self-employment) other than this employer? _____Yes____No

If yes, please provide name and address_____

_____

Do you enjoy listening to "loud" music? _____Yes _____No

If yes, would you describe as _____Frequent _____Seldom

_____ _____

Signature Date