EMPLOYEE HEALTH

The University of Alabama at Birmingham

UAB EMPLOYEE HEALTH
Audiology Questionnaire

Name: _____ Date of Birth: _____ Date: _____

Blazer ID: _____ Last 4 of SSN: _____ Age: _____

Work Phone: _____ Work Location: Building _____ Room_____

Job Title:_____ Supervisor: _____

Male _____ Female _____ Height: _____ft _____in Weight: _____ lbs

Describe your work that relates to loud noises: _____

_____

Current information: **Please *circle* your response.**

Hours since your last exposure to loud noise?	Less than or equal to 14 hours	Greater than 14 hours
Shift	1st shift 2nd shift	3rd shift Rotate shifts
Protector type	None Ear muffs Foam ear plugs	Custom earplugs Ear muffs AND ear plugs
Frequency of protector use	Not used Used sometimes	Usually used Always used
Self-evaluation: Please rate your hearing	Very good Good Average	Poor Very poor Unknown

Have you EVER worked in loud noise? ☐ YES ☐ NO If yes, please describe:

_____

_____

Please answer the following questions by *circling* your response:

Have you recently experienced pain in either ear?..... NO LEFT RIGHT BOTH
Have you recently experienced a draining ear?..... NO LEFT RIGHT BOTH
Have you recently experienced dizziness?..... YES NO
Have you recently experienced severe tinnitus (ringing)?..... NO LEFT RIGHT BOTH
Have you recently experienced sudden hearing loss?..... NO LEFT RIGHT BOTH
Have you recently experienced fluctuating hearing loss?..... NO LEFT RIGHT BOTH
Have you recently experienced ear fullness or discomfort?..... NO LEFT RIGHT BOTH
Have you recently had problems wearing hearing protection?..... ☐ Don't Wear YES NO

Medical History:

Have you ever served in the military?..... YES NO

Please check the division and list dates:

☐ Army ☐ Navy ☐ Air Force ☐ Marines ☐ National Guard Dates:_____

Have you ever been to a doctor for an ear-related problem?..... NO LEFT RIGHT BOTH

Have you ever had a severe head injury?..... YES NO

Have you ever had a stroke?..... YES NO

Have you ever had chemotherapy, IV antibiotics?..... YES NO

Have you ever had ear surgery/tubes?..... NO LEFT RIGHT BOTH

Have you ever had an ear injury?..... NO LEFT RIGHT BOTH

Have you ever had measles?..... YES NO

Have you ever had mumps?..... YES NO

Have you ever had kidney disease?..... YES NO

Have you ever had scarlet fever?..... YES NO

Have you ever had meningitis?..... YES NO

Do you have diabetes?..... YES NO

Do you have high blood pressure?..... YES NO

Do you have an existing hearing problem?..... YES NO

Do you have frequent ear infections?..... NO LEFT RIGHT BOTH

Do you have frequent sinus infections?..... YES NO

Do you shoot or have ever shot guns or hunt?..... YES NO

Do you wear a hearing aid?..... YES NO

Have you *ever* worn hearing aids? ☐ YES ☐ NO Date fitted: _____

If yes, which ear(s)? ☐ RIGHT ☐ LEFT ☐ BOTH

What size? ☐ Behind the ear ☐ In the ear ☐ In-the-canal ☐ Completely-in-the-canal

What type? ☐ Analog ☐ Digital ☐ Don't know

Who fit your hearing aids? ☐ Licensed Audiologist ☐ Hearing Aid Dealer ☐ Don't know

Do you participate in loud activities (music, motorcycle)?..... YES NO

Do you currently use prescription or over the counter drugs (aspirin, etc.)?..... YES NO

Are you currently suffering from allergies?..... YES NO

Does any of your immediate family have hearing problems?..... YES NO

Please check *ALL* of the following that you have *EVER DONE IN YOUR LIFETIME*:

☐ Hunting
☐ Power tools
☐ Welding
☐ Saws
☐ Farm equipment
☐ Electric trimmers
☐ Concerts/Band
☐ Target Shooting
☐ Woodwork
☐ Electric Drills
☐ Air Compressor
☐ Lawn equipment
☐ Mower
☐ Skeet shooting
☐ Construction
☐ Routers
☐ Tractor (open or closed cab)
☐ Leaf blowers
☐ Car races

Please check those that apply to you. Do you…

☐ Feel that everyone mumbles
☐ Often asks "huh?" or "what?"
☐ Talk loudly
☐ Have sensitivity to average or loud sounds
☐ Have difficulty hearing in noisy areas
☐ Have difficulty remembering what is heard
☐ Misunderstand rapid or muffled speech
☐ Have difficulty hearing at church
☐ Seem to hear but not understand
☐ Ask for speakers to repeat themselves
☐ Listen to TV/radio at high volume
☐ Startled by loud noises
☐ Have trouble hearing women or children's voices
☐ Have trouble determining location of sounds
☐ Have trouble hearing on telephone
☐ Have trouble understanding lyrics to songs

Does your family think you have a problem with hearing or understanding? ☐ YES ☐ NO

If yes, please describe examples: _____

_____

_____

_____

Comments:

Do you have any other comments on the health of your hearing? _____

_____

_____

_____

_____ _____

Employee Signature Date

EXAMINER ONLY

1. Subject has visible wax or object in ear? ☐ YES ☐ NO
2. Subject should be referred? ☐ YES ☐ NO

Notes: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Examiner Date