



**Occupational
Medicine
Services**

Bethesda Care Arrow Springs
Phone: 513-282-7075
Fax: 513-282-7076

Bethesda Care Butler County
Phone: 513-874-3990
Fax: 513-860-5071

Bethesda Care Eastgate
Phone: 513-752-3695
Fax: 513-752-3039

Bethesda Care Norwood
Phone: 513-731-3399
Fax: 513-731-2882

Bethesda Care Queensgate
Phone: 513-241-4135
Fax: 513-241-6510

Bethesda Care Sharonville
Phone: 513-563-1505
Fax: 513-769-4776

Good Samaritan
Phone: 513-862-2875
Fax: 513-862-2860

HEARING QUESTIONNAIRE

Name: _____

SSN: _____

Employer: _____

Date of Birth: _____

Please answer the following questions.

Have you ever had:	YES	NO
Frequent earaches, ear infections or ear drainage?	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in the ear, dizziness or numbness of the face?	<input type="checkbox"/>	<input type="checkbox"/>
Excessive ear wax?	<input type="checkbox"/>	<input type="checkbox"/>
Eardrum puncture?	<input type="checkbox"/>	<input type="checkbox"/>
Concussion, head or ear injury?	<input type="checkbox"/>	<input type="checkbox"/>
Ear surgery recommended or performed?	<input type="checkbox"/>	<input type="checkbox"/>
Hearing aid?	<input type="checkbox"/>	<input type="checkbox"/>
Measles, mumps, chicken pox, scarlet fever, diphtheria, meningitis?	<input type="checkbox"/>	<input type="checkbox"/>
Exposure to an explosion or blast?	<input type="checkbox"/>	<input type="checkbox"/>
Past experience in a noisy environment?	<input type="checkbox"/>	<input type="checkbox"/>
Prior military service and/or exposure to artillery?	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
Have any of your blood relatives (mother, father, sister or brother only) had a hearing loss before the age of 50?	<input type="checkbox"/>	<input type="checkbox"/>
Have you noticed a change in your hearing during the past year?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have trouble hearing or understanding normal conversation?	<input type="checkbox"/>	<input type="checkbox"/>
Do you regularly participate in an activity using firearms, power tools, snowmobiles, airplanes, motorboats, motorcycles or farm machinery?	<input type="checkbox"/>	<input type="checkbox"/>
Do you currently work in a noisy area where hearing protection is required?	<input type="checkbox"/>	<input type="checkbox"/>
Do you currently wear hearing protection? Check those that apply: <input type="checkbox"/> Plugs <input type="checkbox"/> Muffs <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
In the past 14 hours, have you been exposed to loud noise without hearing protection?	<input type="checkbox"/>	<input type="checkbox"/>
In the past three days, have you had a cold, flu or sinus condition?	<input type="checkbox"/>	<input type="checkbox"/>

Patient's Signature: _____

Date: _____