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