Date:	Appt. time:	Arrival time:	Time in:	Time out:	Med Rec #:

HEARING CONSERVATION PROGRAM

Patient completes this section

Name:	SSN:	DOB:
Address:	City:	State, Zip:
Phone (home):	(work):	Sex:
Employer:	Dept:	Job:

	Yes	No
1. Have you been exposed to loud noises in the last 14 hours without hearing protection?*	☐	☐
2. Do you have a cold today?**	☐	☐
3. Have you ever been told or noticed that you are hard of hearing?	☐	☐
4. Do you have ringing or buzzing in your ears?	☐	☐
5. Do you have a history of ear infections or surgery to your ears?	☐	☐
6. Do you normally use hearing protection at work? If so, what kind? _____	☐	☐

7. History: Please list below any past exposure to noise including military, jobs, hobbies or activities. Then, in the Yes/No column, indicate whether you used hearing protection during these activities.

	Hearing Protection? Yes	No
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐

*If yes to 1, audiogram must not be performed today. **If yes to 2, it is suggested the audiogram be postponed.

Examiner/staff completes this section

Date:_____
Time:_____

	500	1000	2000	3000	4000	6000	8000
Right							
Left							

Otoscopic inspections

Test Room | Booth Checked | Audiometer #

Comments

Examined by _____