WORKNET
Occupational Medicine
Work Safe. Work Smart.
managed by NovaCare

AUDIOGRAM / OTOLOGIC MEDICAL HISTORY

DATE _____

LAST NAME _____ **FIRST NAME** _____ **Date of Birth** _____

Company/Employer Name: _____

MEDICAL HISTORY FOR PATIENT TO COMPLETE

Have you been told you have a hearing loss?	☐ Yes	☐ No
Have you had a prior audiogram?	☐ Yes	☐ No
Have you been exposed to loud noise in the last 14 hours?	☐ Yes	☐ No
Do you have a head or sinus cold TODAY?	☐ Yes	☐ No
I was not using hearing protection before this test?	☐ Yes	☐ No

High blood pressure?	☐ Yes	☐ No
Meningitis?	☐ Yes	☐ No
Diabetes?	☐ Yes	☐ No
Kidney Disease?	☐ Yes	☐ No
Allergies or hay fever?	☐ Yes	☐ No
Dizziness or unbalance due to ears?	☐ Yes	☐ No
Recently prescribed drug?	☐ Yes	☐ No

If yes, please specify: _____

Mumps ☐ Yes ☐ No
(If Yes, when?) ☐ Child ☐ Teen ☐ Adult

Scarlet fever ☐ Yes ☐ No
(If Yes, when?) ☐ Child ☐ Teen ☐ Adult

Measles ☐ Yes ☐ No
(If Yes, when?) ☐ Child ☐ Teen ☐ Adult

OFFICE USE ONLY

Affix
Audiogram Results
HERE

SOCIAL HISTORY FOR PATIENT TO COMPLETE

Military service?	☐ Yes	☐ No
Noisy hobbies (Ex: hunting, shooting, racing)?	☐ Yes	☐ No
Listening to loud music or using headphones?	☐ Yes	☐ No
Used firearms/guns in the past?	☐ Yes	☐ No

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING IN THE LAST 12 MONTHS

Please note: IF YES, note which ear you are experiencing issues.

Ear Pain?	☐ Yes	☐ No	(Yes?)	☐ Left Ear	☐ Right Ear	☐ Both Ears
Draining?	☐ Yes	☐ No	(Yes?)	☐ Left Ear	☐ Right Ear	☐ Both Ears
Severe or constant ringing noise in ears?	☐ Yes	☐ No	(Yes?)	☐ Left Ear	☐ Right Ear	☐ Both Ears
Sudden hearing loss?	☐ Yes	☐ No	(Yes?)	☐ Left Ear	☐ Right Ear	☐ Both Ears
Hearing loss that comes and goes?	☐ Yes	☐ No	(Yes?)	☐ Left Ear	☐ Right Ear	☐ Both Ears
A feeling of fullness or discomfort in the ear?	☐ Yes	☐ No	(Yes?)	☐ Left Ear	☐ Right Ear	☐ Both Ears
An ear problem related to using hearing protective devices?	☐ Yes	☐ No	(Yes?)	☐ Left Ear	☐ Right Ear	☐ Both Ears
A visit to the doctor for ear problems	☐ Yes	☐ No	(Yes?)	☐ Left Ear	☐ Right Ear	☐ Both Ears
Ear surgery?	☐ Yes	☐ No	(Yes?)	☐ Left Ear	☐ Right Ear	☐ Both Ears
Do you wear a hearing aid?	☐ Yes	☐ No	(Yes?)	☐ Left Ear	☐ Right Ear	☐ Both Ears
Ear wax build up or object in the ear canal?	☐ Yes	☐ No	(Yes?)	☐ Left Ear	☐ Right Ear	☐ Both Ears
Unconsciousness or head injury?	☐ Yes	☐ No				
Hearing loss in the family?	☐ Yes	☐ No	**Who?** _____			
Have you ever worked in a noisy job other than this company?	☐ Yes	☐ No	**Where?** _____			

OFFICE USE ONLY
Audiogram Results entered into Agilty: Staff initials: _____ **Date:** _____