



# BUSINESS HEALTH PARTNERS

"Partners with Business & Industry"

## AUDIO HISTORY

NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_

Do you or have you ever had any of the following? If so explain in comments:

Yes No

- Been to an ear specialist
- Frequent or severe ear infections
- Ringing or buzzing noise in ears
- Problems with balance or dizziness
- Scuba dived or piloted a plane
- Difficulty hearing
- Noisy hobbies or activities – heavy equipment operation, chain sawing, etc
- In the past have you taken any medications on a regular basis
- Do you wear hearing protection
- Sudden hearing loss
- Ear drainage, pain or pressure
- Ear surgery performed or recommended
- Exposed to gunfire or loud noises in the military
- Exposed to loud noise in past 14 hours
- Had a head injury
- \_\_\_\_\_ How long have you consecutively worked for this company?

COMMENTS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

### (For Office use only)

LEFT EAR      RIGHT EAR  
Y      N      Y      N

AUDIO OBSERVATION				
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Comments: \_\_\_\_\_