TOTAL URGENT CARE
Occupational Medicine
314 Highway 3162
Cut Off, LA 70433
Phone: (985) 632-1820 Fax: (985) 632-1824

HEARING HISTORY

(TO BE COMPLETED BY THE EMPLOYEE – PLEASE PRINT)

NAME: _____ DATE: _____

SSN: _____ DOB: _____ EMPLOYER: _____

	YES	NO
Have you been exposed to loud noises during the past 14 hours on or off the job?	☐	☐
Do you have a cold, sinus, or nasal congestion from any cause?	☐	☐
Do you wear hearing protection at work?	☐	☐
Have you ever had:	☐	☐
Ear infection or drainage	☐	☐
Ear surgery or injury	☐	☐
Deafness	☐	☐
To use a hearing aid	☐	☐
Family history of deafness	☐	☐
Ear ringing or a buzzing sounds	☐	☐
Ear pain	☐	☐
Meningitis, tumors, hemorrhage, or blood vessel disease that caused deafness	☐	☐
Childhood disease that caused deafness	☐	☐
Use of drugs that can cause deafness, such as aspirin or mycin antibiotics?	☐	☐
Are you now or have you ever been exposed to loud noises on the job?	☐	☐

If yes, please explain where and when_____
_____

Are you now or have you ever been exposed to loud noises while not at work? _____
If yes please explain (hunting, target shooting, listening to loud music, etc.) _____
_____

Comments on history _____
_____
_____
_____

To be completed by examining (circle one): Physician Mid-Level Provider Nurse Technician

Is there evidence of otitis media, otitis externa, wax impaction, foreign body, perforated eardrum, or other condition that could affect hearing, or the use of hearing protection?	☐	☐

If YES, please explain
_____
_____
_____

_____ _____

EXAMINER **REVIEWING PHYSICIAN**