Walk-In Clinic
ACADIAN HEALTH SERVICES, INC.

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Phone 337-234-9925 • Fax 337-237-5211

Occupational Medicine: Audiogram History Record - Patient to Complete Shaded Area

Name: _____ Date: _____

Address: _____

DOB: _____ SSN: _____

How do you rate your own hearing: ☐ Good ☐ Fair ☐ Poor If other than Good, why?

_____

Have you ever seen a doctor for ear trouble? ☐ Yes ☐ No

If yes, who? _____ When? _____

Has there been anyone in your family with a hearing loss before age 50? ☐ Yes ☐ No

If yes, who? _____

Do you have or have you had any of the following:

Measles	☐ Yes	☐ No	Ringing in ears	☐ Yes	☐ No
Mumps	☐ Yes	☐ No	Dizziness	☐ Yes	☐ No
Scarlet Fever	☐ Yes	☐ No	Earaches	☐ Yes	☐ No
Head Injury	☐ Yes	☐ No	Perforated eardrum	☐ Yes	☐ No
Sinus Trouble	☐ Yes	☐ No	Drainage from ear	☐ Yes	☐ No
Allergy	☐ Yes	☐ No	Excessive Wax	☐ Yes	☐ No

Do you have a cold now? ☐ Yes ☐ No

What antibiotics have you taken (Penicillin, Streptomycin, etc.)? _____

Military Service – Branch _____ Dates: _____

Assignments: _____ Any hearing disability? Yes ☐ No ☐

How often do you use firearms? _____

Do you own, use, ride a motorcycle?	☐ Yes	☐ No	Do you use earphones to listen to stereo	☐ Yes	☐ No
Do you repair motors?	☐ Yes	☐ No	Have you ever worked in a noisy area or been required to		
Do you race cars, boats?	☐ Yes	☐ No	wear ear protection?	☐ Yes	☐ No
Do you use a power saw?	☐ Yes	☐ No	Where?_____When?_____		
Do you use a snowmobile?	☐ Yes	☐ No	How Long?_____		
Do you use a dune buggy?	☐ Yes	☐ No	Was ear protection provided?	☐ Yes	☐ No
Do you play a musical instrument?	☐ Yes	☐ No	Was ear protection worn?	☐ Yes	☐ No
What?_____			Type worn?_____		
Do you, or have you scuba dived?	☐ Yes	☐ No			
Greatest Depth:_____					

Note any additional comments you have about your hearing: _____

Employee Signature: _____ Date: _____