ST. GEORGE'S MEDICAL CLINIC

AUDIOMETRIC SCREENING QUESTIONNAIRE

Patient Name: _____ **DOB:** _____ **Date:** _____

Employer: _____ **Job Title:** _____

Reason for Test: ☐ Baseline ☐ Annual ☐ Post-Offer ☐ Follow-up ☐ Other

		Yes	No	N/A
Hearing / Ear History				
1.	Have you noticed any hearing loss or difficulty hearing?	☐	☐	☐
2.	Do you have trouble understanding speech, especially with background noise?	☐	☐	☐
3.	Is hearing worse in one ear than the other?	☐	☐	☐
4.	Do you have ringing, buzzing, or other noises in your ears (tinnitus)?	☐	☐	☐
5.	Do you have ear pain, pressure/fullness, drainage, or a current ear infection?	☐	☐	☐
6.	Do you have a blocked-ear feeling or history of excessive ear wax?	☐	☐	☐
7.	Have you ever had ear surgery, a ruptured eardrum, or a serious ear injury?	☐	☐	☐
8.	Do you have dizziness, vertigo, balance problems, or use hearing aids/devices?	☐	☐	☐
Noise Exposure / Hearing Protection				
9.	Are you regularly exposed to loud noise at work?	☐	☐	☐
10.	Did you have loud noise exposure within the last 14 hours?	☐	☐	☐
11.	Are you exposed to loud noise for most of a work shift or more than 8 hours?	☐	☐	☐
12.	Do you consistently wear hearing protection when required at work?	☐	☐	☐
13.	Have you been trained on proper use and fit of hearing protection?	☐	☐	☐
14.	Do you use double protection when noise is very loud?	☐	☐	☐
15.	Do you have loud noise exposure outside of work (music, tools, motorcycles, firearms, etc.)?	☐	☐	☐
16.	Have you ever had a significant one-time loud noise exposure, blast, gunshot, or explosion?	☐	☐	☐
Medical / Occupational History				
17.	Have you previously had an abnormal hearing test or standard threshold shift?	☐	☐	☐
18.	Has a healthcare provider ever told you that you have hearing loss?	☐	☐	☐
19.	Have you had a head injury, concussion, blast exposure, or severe whiplash?	☐	☐	☐
20.	Have you had recurrent ear infections or chronic ear problems?	☐	☐	☐
21.	Are you taking medications that may affect hearing or balance?	☐	☐	☐
22.	Do you currently have a cold, sinus congestion, allergies, or ear pressure?	☐	☐	☐
23.	Do you have a family history of hearing loss?	☐	☐	☐

If yes to any of the above, please explain: _____

Type of noise exposure / hearing protection used: _____

I certify that the information provided above is true and accurate to the best of my knowledge. I understand this screening is used to evaluate hearing status and that follow-up may be recommended if needed.

Patient Signature: _____ **Date:** _____