Audiology Services
10201 SE Main Street
Suite 4
Portland OR 97216
503.251.6350

Adventist Health

OSHA RECORDABLE QUESTIONNAIRE

PLEASE PRINT

Company:	City:	State:
Name:		DOB:
Job Title:	Noise Exposure Level (TWA): ☐ check here if unknown	
Do you work with the majority of noise coming from one side? ☐ Yes ☐ No If Yes, which side? ☐ Left ☐ Right	Do you wear a shoulder-mounted radio? ☐ Yes ☐ No If Yes, which side? ☐ Left ☐ Right	
Have you ever had an explosion or blast to your ear? ☐ Yes ☐ No If Yes, which side? ☐ Left ☐ Right	Have you ever had radiation or chemotherapy? ☐ Yes ☐ No Explain:	
Do you work around Industrial chemicals? ☐ Yes ☐ No If Yes, list name(s):	Do you work a second job? ☐ Yes ☐ No Explain:	
Do you work around loud noise? ☐ Yes ☐ No	Type of Hearing Protector Used:	
Average hours/day you work?	% of time used at work:	

OFF-THE-JOB ACTIVITIES

Have you ever done the following:	TIME PERIOD (years)	USED HEARING PROTECTION?
Wood working	☐ No ☐ Yes; From _____ to _____	☐ No ☐ Yes
Metal working	☐ No ☐ Yes; From _____ to _____	☐ No ☐ Yes
Heavy equipment	☐ No ☐ Yes; From _____ to _____	☐ No ☐ Yes
Chain saws	☐ No ☐ Yes; From _____ to _____	☐ No ☐ Yes
Grinders/chippers	☐ No ☐ Yes; From _____ to _____	☐ No ☐ Yes
Air-driven tools	☐ No ☐ Yes; From _____ to _____	☐ No ☐ Yes
Motor sports	☐ No ☐ Yes; From _____ to _____	☐ No ☐ Yes
Farm machinery	☐ No ☐ Yes; From _____ to _____	☐ No ☐ Yes
Airplanes	☐ No ☐ Yes; From _____ to _____	☐ No ☐ Yes
Music (bands, concerts, headset)	☐ No ☐ Yes; From _____ to _____	☐ No ☐ Yes
Firearms which hand? R L	☐ No ☐ Yes; From _____ to _____	☐ No ☐ Yes

MORE ON BACK SIDE

Leaf blower/trimmer	☐ No ☐ Yes; From _____ to _____ ☐ No ☐ Yes

CURRENT CONDITIONS (Are you currently experiencing the following?)

	PLEASE EXPLAIN
Ear pain	☐ No ☐ Yes;
Ear drainage	☐ No ☐ Yes;
Ear fullness or pressure	☐ No ☐ Yes;
Sudden hearing loss	☐ No ☐ Yes;
Severe ringing	☐ No ☐ Yes;
Dizziness	☐ No ☐ Yes;
Fluctuating hearing loss	☐ No ☐ Yes;
Ear problem w/ protectors	☐ No ☐ Yes;
Use a hearing aid	☐ No ☐ Yes;
Seen a doctor for ears	☐ No ☐ Yes;

HEALTH HISTORY (Have you ever had the following conditions?)

	Please explain
High blood pressure	☐ No ☐ Yes;
Diabetes	☐ No ☐ Yes;
Parents with hearing loss	☐ No ☐ Yes;
Meniere's disease	☐ No ☐ Yes;
Viral infection	☐ No ☐ Yes;
Hearing loss as a child	☐ No ☐ Yes;
High cholesterol	☐ No ☐ Yes;
Smoking	☐ No ☐ Yes;
Ear problems	☐ No ☐ Yes;
Ear infections (discharge)	☐ No ☐ Yes;
Ear surgery	☐ No ☐ Yes;
Dizziness (vertigo)	☐ No ☐ Yes;
Ear tumors	☐ No ☐ Yes;
Hole in eardrum	☐ No ☐ Yes;
Antibiotics for infection	☐ No ☐ Yes;
Measles	☐ No ☐ Yes;
Mumps	☐ No ☐ Yes;
Meningitis	☐ No ☐ Yes;

MORE ON BACK SIDE

Scarlet fever	☐ No ☐ Yes;
Kidney disease	☐ No ☐ Yes;
Head injury	☐ No ☐ Yes;

MEDICATIONS - Please list all current medications and dosage.

_____

_____

_____

Do you think your hearing loss is caused by work noise? Explain...

_____

_____

_____

Are there situations you find difficult to hear? Explain...

_____

_____

_____

Additional Comments:

_____

_____

_____

I acknowledge the above information is accurate to the best of my knowledge and authorize release of this information to my Employer for the purpose of determining OSHA recordability of my hearing loss.

Employee signature:_____Date:_____

Reviewed by:_____Date:_____

MORE ON BACK SIDE