Audiological Test

Name:			Date:
Home Address:			
Date of Birth:	Sex: M/F	SS#	Home Phone:
Company Name:			Occupation:

Patient History

1. Is anyone in your family deaf? Yes No
2. Have you ever had a hearing test? Yes No
3. Have you ever had ringing in your ears Or any other ear trouble? Yes No
4. Have you ever been to a doctor for ear trouble or been advised to see an audiologist? Yes No
   If Yes, When and Why? ____________________________
   ____
5. Do you use firearms?
   ____
6. Are you exposed to any loud noises at your work place? Yes No
7. Did you wear hearing protectors 24 hours prior to this test? Yes No

**This is to clarify that the above answers are true and answered to the best of my knowledge.

SIGNED_________________________________

TYPE OF TEST: __PRE-EMPLOYMENT __ BASELINE __ANNUAL __OTHER__________

Audio Make/Model: TBD **Serial No:** TBD **Date:** ____________ **Time:** _____________

Exhaustive Calibration Date: ______ **Acoustic (Annual) Calibration Date:** ______________

Test Results:

Frequency	500	1000	2000	3000	4000	6000	8000	500	1000	2000	3000	4000	6000	8000
Decibel Loss														

LEFT EAR **RIGHT EAR**

NOTE: IF THIS IS PART OF AN ANNUAL SURVAILLANCE PROGRAM, RESULTS SHOULD BE COMPARED TOTHE ESTABLISHED BASELINE.

TESTED BY: ____