

HEARING TEST FORM

PRINT ONLY

Directions on reverse side.

URGENT CARE / FAMILY PRACTICE

COMPANY NAME

LOCATION (City-State)

A

DIVISION

PLANT #

B

DATE OF BIRTH

SEX

SOCIAL SECURITY NUMBER

Name (Print)

Employee Clock #/ID #

Mo Day Yr

First Initial Last

C

DEPARTMENT CODE

JOB TITLE/POSITION

YEARS EMPLOYED

NOISE EXPOSURE
dBA %DOSE

EAR PROTECTION
TYPE YEARS WORN

CIRCLE THE NUMBER IN D,E,F,G IF ANY ITEM APPLIES TO YOU

PRINT THE # OF YEARS IN H

D

HEARING LOSS IN FAMILY

E

DISEASES OR INFECTIONS

F

EAR PROBLEMS AND SYMPTOMS

G

INJURY TO HEAD OR EAR

H

NON-OCCUPATIONAL ACTIVITY YEARS

- 1 MOTHER before age 50
- 2 FATHER before age 50
- 3 AUNTS before age 50
- 4 UNCLES before age 50
- 5 SISTERS before age 50
- 6 BROTHERS before age 50
- 7 DAUGHTERS
- 8 SONS
- 9 YOURSELF

- 1 MEASLES
- 2 MUMPS
- 3 KIDNEY DISEASE
- 4 SCARLET FEVER
- 5 DIABETES
- 6 HIGH FEVER as a Baby
- 7 ALLERGIES
- 8 MENINGITIS
- 9 HIGH BLOOD PRESSURE

- 1 Medical Care for Ears
- 2 DRAINING EARS
- 3 Ear Aches or Infection
- 4 EAR SURGERY
- 5 HEARING AID
- 6 EXCESS EAR WAX
- 7 RINGING IN EARS
- 8 FACE FEELS NUMB
- 9 DIZZINESS

- 1 SEVERE BLOW TO HEAD
- 2 KNOCKED OUT
- 3 SKULL FRACTURE
- 4 OTHER HEAD INJURY
- 5 EARDRUM PUNCTURE
- 6 EXPLOSION or BLAST
- 7 AUTO ACCIDENT
- 8 FLYING or SKYDIVING
- 9 DIVING ACCIDENT

- Active Military Duty _____
- Artillery-Flying _____
- Hunting/Shooting _____
- Private Flying _____
- Loud Music _____
- Home Power Tools _____
- Home Tractor-Machinery _____
- Power Boats-cycles _____
- Any Other Noise _____

CURRENT SYMPTOMS: HAVE YOU WITHIN THE LAST 24 HOURS...

- 1 HAD RINGING IN YOUR EARS? YES NO
- 2 HAD A COLD, FLU OR SINUS CONDITION? YES NO
- 3 HAD AN EARACHE? YES NO
- 4 BEEN EXPOSED TO LOUD NOISE WITHOUT HEARING PROTECTION? YES NO
- 5 TAKEN MEDICATIONS, INCLUDING ASPIRIN OR ANTIBIOTICS? YES NO

COMMENTS: _____

J

OTOSCOPIC SCREENING:
(Circle one)

LEFT EAR: N P D B O S

RIGHT EAR: N P D B O S

AUDIOMETRIC TEST:
TEST DATE

LEFT EAR TEST RESULTS

RIGHT EAR TEST RESULTS

Mo.	Day	Yr.	TIME	500	1000	2000	3000	4000	6000	8000	500	1000	2000	3000	4000	6000	8000

Latest Audiometer Acoustical Calibration Date _____

Test Performed by _____ Certification No. _____

Employee Signature _____

→ PLEASE ATTACH MICROPROCESSOR TAPE HERE WITH TEST RESULTS VISIBLE

DIRECTIONS FOR COMPLETING HEARING TEST FORM

Section A

Complete your company's name and location information. Division and/or plant numbers or codes should be included if used by your company.

Section B

Complete this section with employee's birthdate, sex, social security number, name, and employee clock number (if applicable). Section B is **mandatory**; the employee's test cannot be processed without the information.

Section C

IMPACT recommends that all information in this section be completed for the most beneficial reports. If applicable, check with your corporate office to see if a specific coding system has been devised by your company.

- Department Code: This information is required if a department analysis report is desired. Department codes must be entered **consistently** and **accurately** for a meaningful department report.
- Job Title/Position: Employment category, job title or position.
- Years Employed: Number of years employed with your company.
- Noise Exposure:
 - dBA—results of a recent survey conducted in the employee's work area with a sound level meter set to "A" scale, slow response (time-weighted-average).
 - % Dose—results of dosimetry, if available (percent daily exposure or noise dose).
- Hearing Protection:
 - Type—type or brand of hearing protection devices worn. Recommended codes:

FF—Foam plugs	CP—Custom-molded plugs
PP—Pre-molded plugs (solid)	GP—Glass fiber plugs
LP—Liquid-filled plugs	EM—Earmuffs
AP—Air-filled plugs	CC—Canal caps/banded plugs
 - Years worn—number of years hearing protection devices worn.

Section D Hearing Loss in Family:

If any family member has had a hearing loss (complete or partial), circle the number beside that family member. If the employee has had a hearing loss, circle number 9.

Section E Diseases or Infections:

Circle the number beside any of these diseases or infections which the employee has had, even as a child. Number 6 "high fever" refers to a temperature of 103° or more for a 24-hour period. Number 9 "high blood pressure" refers to medication for high blood pressure prescribed by a physician.

Section F Ear Problems and Symptoms:

Circle the number beside any information that applies. Number 6 "excess ear wax" refers to those individuals requiring annual visits to a physician to have the excess wax removed.

Section G Injury to Head or Ear:

Circle the number beside any information that applies. Number 8 "flying or skydiving" refers to an accident or injury occurring during these activities. Number 9 "diving accident" refers to underwater diving only.

Section H Non-Occupational Activity:

List the approximate number of years that the individual has regularly participated in any of these activities. For example, if the employee served in the military, list the number of years served. Other categories such as "home power tools" refer to consistent use, not just occasional use.

Section I Current Symptoms:

This section is for current symptoms only (within last 24 hours).

Section J

- Otoscopy: IMPACT highly recommends that otoscopic examinations be performed. The following codes must be used. Please circle appropriate code.

N = No Apparent Problem	D = Possible Disease	O = Partial Obstruction
P = Possible Perforation	B = Blockage (Complete)	S = Surgery or Scarring
- Test Date: The month, day and year of the test **must** be completed for all years of data submitted. Time of test must be recorded in nautical time (i.e., 3:00 p.m.=1500).
- Hearing Test Results: Hearing test data (threshold values) **must** be completed. Minimum test frequencies are 500, 1000, 2000, 3000, 4000, and 6000 Hz. 8000 Hz is optional except when required by state law and/or company policy. No response at the highest intensity of the audiometer should be recorded as "NR."

Also complete additional information at bottom of form and obtain employee's signature.

Additional information for completion of this form may be obtained from IMPACT's Information Services Department (816) 471-3900 or 1-800-9-IMPACT.