WORKMAN'S COMP APPOINTMENTS

1. PT MUST STAY AWAY FROM NOISE FOR 24 HOURS PRIOR TO APPOINTMENT

2. THERE MUST BE AN AUTHORIZATION AND CLAIM NUMBER SENT PRIOR TO APPOINTMENT

3. DATE OF ACCIDENT INCLUDED ON THE AUTHORIZATION

4. MAILING ADDRESS OF ADJUSTER WITH COMP CARRIER TO WHERE CLAIM MAY BE SENT TO

5. AUTHORIZATION MUST CONTAIN CONTACT PERSON NAME AND PHONE NUMBER

***AUTHORIZATION MUST BE ON COMPANY LETTER HEAD

NOISE EXPOSURE QUESTIONAIRE

Name: _____

Referred By: _____

A. HEARING LOSS

1. How old are you? _____ years

2. What year did hearing loss begin? _____

3. Did you have any problem hearing before the date stated in Question #2

   _____

4. How would you evaluate your hearing?

   Good _____ Fair _____ Poor _____

5. From which ear do you hear better?

   Left _____ Right _____ No Difference _____

6. Do you hear better in a quiet or noisy place?

   Quiet _____ Noisy _____ No Difference _____

7. Do you hear well over the Telephone?

   Yes _____ No _____

8. Can you hear the telephone ring from the next room?

   Yes _____ No _____

9. Have you ever noticed a TEMPORARY (for minutes or hours) decrease in your hearing after noise exposure?

   Yes _____ No _____

10. Have you ever worn a hearing aid?

    Yes _____ No _____

11. Do you have any ringing in your ears?

Yes _____ No _____

If yes:

a. When did you first notice it? Year _____

b. Describe what it sounds like:

_____
_____
_____

12. Have you ever noticed a TEMPORARY (for minutes or hours) ringing in your ears after noise exposure?

Yes _____ No _____

If yes, what noises were you exposed to before hearing the ringing?

_____
_____
_____

13. Have you ever had any drainage from your ears?

Yes _____ No _____

If yes, please describe:

_____
_____

14. Have you ever had any dizziness?

Yes _____ No _____

If yes, please describe:

_____
_____

15. Have you had any ear infections?

Yes _____ No _____

If yes, please describe:

_____
_____

16. Have you ever had your hearing tested before?

Yes _____ No _____

If yes, when was your first test? Year _____

Where? _____

17. Have you ever seen a doctor about your hearing?

Yes _____ No _____

If yes:

a. Doctor's Name: _____

b. What did the Doctor say was wrong? _____

_____

_____

18. Have you ever taken or been given any of the following medictions?

	Yes	No
Antibiotics by shot	_____	_____
Aspirin on a daily basis	_____	_____
Any medicine long term	_____	_____

If yes, what was/were the medication/s _____

_____

19. List all surgeries you have had (if any)

_____

_____

_____

_____

20. List all hospitalizations (if any)

_____

_____

_____

21. Have you ever had any of the following:

	Yes	No		Yes	No
Ear Surgery	_____	_____	Sudden Hearing change	_____	_____
Ear Injury	_____	_____	Mumps	_____	_____
Ear Aches	_____	_____	Measles	_____	_____
Scarlet Fever	_____	_____	High Fever	_____	_____
loss of consciousness	_____	_____	Any chronic illness	_____	_____
Any medicine long term	_____	_____			

22. Do your parents, brothers, or sisters have hearing loss?

Yes _____ No _____

23. Has any family member had ear surgery?

Yes _____ No _____

B. HEARING LOSS

1. Who is your present (or most recent) employer? _____

_____

2. What is your job title? _____

3. How long have you worked there? _____

4. What loud noise(s) do you have there? _____

_____

5. Do you have to shout to communicate at arm's length while at work?

Yes _____ No _____

If so, how often or what percentage of the time? _____

6. When did you start wearing ear protection? Year_____

7. Do you use muffs or plugs?

No _____ Muffs _____ Plugs _____ Both _____

8. List the places you worked BEFORE your present employer (most recent employer first):

Employer	Location	Type of Work	How Long?	Noise Exposure	Ear Protection
1.					
2.					
3.					
4.					

C. MILITARY SERVICE

1. Were you in the military service? _____

   Yes _____ No _____

2. What branch were you in?

   Army _____ Navy _____ Air Force _____ Marines _____ Other _____

   For how long? _____

3. What was your job in the service? _____

   _____

4. Were you in combat?

   Yes _____ No _____

5. Were you exposed to noise beyond basic training?

   Yes _____ No _____

D. NON-OCCUPATIONAL NOISE

1. Have you ever been exposed to any of the following outside of your work?

	Yes	No		Yes	No
Snowmobile	_____	_____	Small Engine	_____	_____
Motorcycle	_____	_____	Firing Range	_____	_____

	Yes	No		Yes	No
Chain Saw	_____	_____	Fire Machinery	_____	_____
Power Tools	_____	_____	Heavy Equipment	_____	_____
Hunting	_____	_____	Trap Shooting	_____	_____
Loud Music	_____	_____	Racing	_____	_____

2. Do you wear ear protection during these activities?

   Yes _____ No _____

   If yes:

   Muffs _____ Plugs _____

E. GENERAL

1. How much time was there between your last exposure to noise and your completing this questionnaire?

   Minutes _____ Hours _____ Days _____

2. When did your last work?

   Minutes _____ Hours _____ Days _____

3. How long did your recent noise exposure last? _____

4. Did you wear ear protection during your most recent exposure?

   Yes _____ No _____

Date:_____

Print Name: _____

Signature:_____