History Questionnaire

1) Are you experiencing hearing difficulty?

No Yes if yes, how long approx.? _____

if yes, which ear is worse? Right Left Unsure

2) Any drainage other than wax from either ear?

No Yes if yes, how long? _____

3) Any dizziness?

No Yes if yes, how long? _____

4) Any tinnitus (ringing, buzzing)?

No Yes if yes, how long_____

if yes, which ear(s) Right Left Unsure

frequency intermittent constant

5) Any ear pain/discomfort?

No Yes if yes, how long_____

if yes, which ear(s) Right Left Unsure

frequency intermittent constant

6) Any history of noise exposure? (Please circle all that apply)

No Yes: Occupational Military Recreational

Occupational only – last day worked? _____

Occupational only – career duration/years with employer? _____

if yes, were hearing protection devices used? Always Sometimes Never

ILWU-PMA only: Local _____ Registration Number: _____

7) Any family history of hearing loss? _____

_____

8) Please circle any other applicable concerns (if applicable):

Memory Vision Falls Other_____

Dexterity Diabetes Blood thinners