Audiology Services
10201 SE Main Street
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Portland OR 97216
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Adventist Health

## OSHA RECORDABLE QUESTIONNAIRE

**PLEASE PRINT**

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