

MEDICAL HISTORY

NAME _____	SS# _____ - _____ - _____	DATE _____
EMPLOYER _____	JOB _____	DOB _____

VITALS [FOR OFFICE USE ONLY] Ht. _____ Wt. _____ B.P. _____ Tech _____

AUDIO Tech's initials _____ (for office use only)

Do you or have you ever had any of the following:	
<input type="checkbox"/> Been to an ear specialist	<input type="checkbox"/> Sudden hearing loss
<input type="checkbox"/> Frequent or severe ear infections	<input type="checkbox"/> Ear drainage, pain or pressure
<input type="checkbox"/> Ringing or buzzing noise in ears	<input type="checkbox"/> Ear surgery performed or recommended
<input type="checkbox"/> Problems with balance or dizziness	<input type="checkbox"/> Exposed to gunfire or loud noises in the military
<input type="checkbox"/> Scuba dived or piloted a plane	<input type="checkbox"/> Exposed to loud noise in past 14 hours
<input type="checkbox"/> Difficulty hearing	<input type="checkbox"/> Had a head injury
<input type="checkbox"/> Noisy hobbies or activities – heavy equipment operation, chain sawing, loud music, etc.	
<input type="checkbox"/> In the past have you taken any medications on a regular basis	<input type="checkbox"/> Do you wear hearing protection
<input type="checkbox"/> None	COMMENTS: _____ _____

MEDICAL

Have you ever had an injury or illness related to your work? <input type="checkbox"/> Yes <input type="checkbox"/> No
If so _____
Have you ever had any back trouble? <input type="checkbox"/> Yes <input type="checkbox"/> No
If so _____
Have you had any operations, accidents, broken bones, or medical illnesses? <input type="checkbox"/> Yes <input type="checkbox"/> No
If so _____
Are you taking any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No
If so _____

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