**CENTER FOR HEARING HEALTH** **TOLL FREE** **800-228-6067** **AUDIOGRAM TRACKING FORM**

NAME (Last)_____(First) _____ Male / Female Date of Birth_____

Company _____ Plant (City) _____ Job Description_____

Department _____ Noise Level (TWA) _____ Co. Emp. # _____ Date of Hire_____ Shift_____

| **GENERAL QUESTIONS** (Answer "Y" for Yes; "N" for No) | Test #1 | Test #2 | Test #3 | Test #4 | Test #5 | Test #6 | Test #7 | Test #8 |
|---|---|---|---|---|---|---|---|---|
| Do you wear hearing protection regularly? | | | | | | | | |
| Have you been exposed to loud noise in the past 14 hours without hearing protection? | | | | | | | | |
| Do you presently have a head cold or severe sinus condition? | | | | | | | | |
| Have you visited a physician for your hearing in the last year? | | | | | | | | |
| **UPDATED HISTORY QUESTIONS** | Y or N | Y or N | Y or N | Y or N | Y or N | Y or N | Y or N | Y or N |
| Are you aware of any hearing loss? | | | | | | | | |
| Do you have a relative with hearing loss? | | | | | | | | |
| Have you had dizziness or balance problems? | | | | | | | | |
| Do you have ringing or roaring in your ears? | | | | | | | | |
| Have you had exposure to fire arms? | | | | | | | | |
| Do you take prescription drugs? | | | | | | | | |
| Have you been in military service? | | | | | | | | |
| Have you ever had your hearing tested? | | | | | | | | |
| Have you ever worked in noise? | | | | | | | | |
| Do you have excessive earwax? | | | | | | | | |
| Do you have earaches or ear drainage? | | | | | | | | |
| Do you have noisy hobbies? | | | | | | | | |
| Have you had a severe head injury? | | | | | | | | |
| **TEST INFORMATION** *(Area for technician use )* | Test #1 | Test #2 | Test #3 | Test #4 | Test #5 | Test #6 | Test #7 | Test #8 |
| Otoscopic Screening (N=Normal B=Blockage P=Partial Block U=Unknown) RE/LE | / | / | / | / | / | / | / | / |
| **Test Booth No.** | | | | | | | | |
| **Test Date** Month | | | | | | | | |
| Day | | | | | | | | |
| Year | | | | | | | | |

| TEST DATE | TEST TIME | SERIAL # Calib.Date | Right .5k | Right 1k/rt1K | Right 2k | Right 3k | Right 4k | Right 6k | Right 8k | Left .5k | Left 1k | Left 2k | Left 3k | Left 4k | Left 6k | Left 8k | Tester Name or CAOHC # |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
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