CHH Center for Hearing Health
HEARING CONSERVATION SERVICES

Please print clearly and complete each field

Company Name:	Plant Location / City:	
Employee Name:	Date of Birth: mo / day / yr	Sex M / F
Company Contact Name:	Company Contact Phone #:	

PLEASE ANSWER YES OR NO TO THE FOLLOWING QUESTIONS	YES	NO
Do you wear hearing protection regularly? / *Utilizas la proteccion del oido?*		
Have you been exposed to loud noise in the past 14 hours without hearing protection? / *Fuiste expuesto(a) a ruido fuerte sin protectors en las ultimas 14 horas?*		
Do you presently have a head cold or severe sinus condition? / *Has tenido catarro o problema del sino las ultimas 24 horas?*		
Have you visited a physician for your hearing in the last year? / *Has visitado un medico acerca tu audencia en el ano pasado?*		
Are you aware of any hearing loss? / *Has perdido el oido?*		
Do you have a relative with hearing loss? / *Tienes algun pariente con perdida de el oido?*		
Have you had dizziness or balance problems? / *Has tenido mareos o problemas de el equilibrio?*		
Do you have ringing or roaring in your ears? / *Tienes zumbido en los oidos ahora?*		
Have you had exposure to fire arms? / *Has estado expuesto a disparo de armas?*		
Do you take prescription drugs? / *Tomas medicinas recetadas?*		
Have you been in military service? / *Estuviste en el servicio militar?*		
Have you ever had your hearing tested? / *Te han hecho la prueba de los oidos?*		
Have you ever worked in noise? / *Has trabajado expuesto al ruido fuerte?*		
Do you have excessive earwax? / *Tienes cerumen excesivo en los oidos?*		
Do you have earaches or ear drainage? / *Te duelen o te agotean los oidos?*		
Do you have noisy hobbies? / *Has tenido pasatiempos ruidosos?*		
Have you had a severe head injury? / *Has sufrido herida grave en la cabeza?*		

Clinic and audiometer information needed to validate this test.

Audiometer Serial #: _____ Make / Model _____

Audiometer Calib. Date: _____Technician: _____

Clinic Name: _____City: _____

Clinic Contact Name: _____ Clinic Phone_____

OTOSCOPIC SCREENING (circle one)

N=appears normal B=appears blocked P=partial blockage U=unknown/not performed

RIGHT Ear - N B P U

LEFT EAR - N B P U

Test Date														
Mo.	Day	Yr.	500	1000	2000	3000	4000	6000	8000	500	1000	2000	3000	4000	6000	8000

Please forward these results to: Center for Hearing Health (Questions:530-888-9977)

By fax: **530-888-1177** By mail: **2945 Bell Rd. #122, Auburn, CA 95603**