**OMB Control Number: 0693-#### Expiration Date: ##/##/####**

**U.S. DEPARTMENT OF COMMERCE**

**NAME** NATIONAL INSTITUTE OF STANDARDS AND TECHNOLOGY

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Last** | **First** | | **Middle** | **SOCIAL SECURITY NO.** | **OPERATING UNIT & LOCATION** | |
| **DATE OF BIRTH** | | **DATE EMPLOYED** | | **JOB ASSIGNMENT** | | **DATE** |

**AUDIOLOGICAL HISTORY**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **OCCUPATIONAL HISTORY (Beginning with last previous, working back to first job.)** | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | |
|  | **EMPLOYER** | | | | | | | **CITY** | | | | | | | **DUTIES** | | | | | | | **DATES OF SERVICE** | | | | **NOISE**  **EXPOSURE** | | | **EAR**  **PROTECTORS** | | |
| **1.** |  | | | | | | |  | | | | | | |  | | | | | | |  | | | | **YES** | | **NO** | **YES** | | **NO** |
| **2.** |  | | | | | | |  | | | | | | |  | | | | | | |  | | | | **YES** | | **NO** | **YES** | | **NO** |
| **3.** |  | | | | | | |  | | | | | | |  | | | | | | |  | | | | **YES** | | **NO** | **YES** | | **NO** |
| **4.** |  | | | | | | |  | | | | | | |  | | | | | | |  | | | | **YES** | | **NO** | **YES** | | **NO** |
| **MILITARY**  **SERVICE** | | | | **TIME SERVED** | | | | | | **BRANCH (OTHER)** | | | | | | | | | | | | | | | | **EXPOSURE TO GUNFIRE AND NOISE**  **YES**  **NO** | | | | | |
| **ARMY**  **NAVY**  **MARINES**  **AIR FORCE** | | | | | | | | | | | | | | | |
| **CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | **HAVE YOU EVER BEEN NOTIFIED THAT YOU HAVE A HEARING LOSS? DATE** | | | | | | | | | | | | | |  | |
|  | | **ALLERGY** | | **DIABETES** | | | | | | | **MUMPS** | | | | | **HEARING LOSS IN FAMILY** | | | | | | | | **SEVERE OR PROLONGED ILLNESS** | | | | | | | |
|  | | **MEASLES** | | **SCARLET FEVER** | | | | | | | **WHOOPING COUGH** | | | | | **HAVE YOU OR ANY MEMBER OF YOUR FAMILY HAD ANY EAR OPERATIONS?**  **YES**  **NO** | | | | | | | | | | | | | | | |
|  | | **MENINGITIS** | | **ENCEPHALITIS** | | | | | | | **HEAD INJURY** | | | | |  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | **DESCRIBE:** | | | | |  | | | | | | | | | | |
| **CHECK IF YOU NOW HAVE ANY OF THE FOLLOWING:** | | | | | | | | | | | | | | | | | |  |  | | | | | | | | | | | | |
|  | **PAIN IN EARS** | | **EAR DISCHARGE** | | | | | | | | **RINGING IN EARS** | | | | | | |  |  | | | | | | | | | | | | |
|  | **TAKING ANY MEDICATIONS** | | | | | | **NAME** | |  | | | | | | | |  |  |
|  | | | | | | | | | | | | | | | | | |  |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| **NON-OCCUPATIONAL NOISE EXPOSURE** | | | | | | | | | | | | | | | | | | | | | | | **YES** | | **NO** | | **HOW OFTEN?** | | | | |
| **HUNTING OR SHOOTING** | | | | | | | | | | | | | | | | | | | | | | |  | |  | |  | | | | |
| **LOUD MUSIC** | | | | | | | | | | | | | | | | | | | | | | |  | |  | |  | | | | |
| **SNOWMOBILE** | | | | | | | | | | | | | | | | | | | | | | |  | |  | |  | | | | |
| **AIRPLANE** | | | | | | | | | | | | | | | | | | | | | | |  | |  | |  | | | | |
| **MOTORCYCLE** | | | | | | | | | | | | | | | | | | | | | | |  | |  | |  | | | | |
| **OTHER** | | | | | | | | | | | | | | | | | | | | | | |  | |  | |  | | | | |
| **PREVIOUS HEARING TEST** | | | | | | **DATE** | | | | | | **COMPANY** | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **IS YOUR HEARING** | | | | | **GOOD** | | | | | | | | **FAIR** | | | | | | | **POOR** | | | | | | | | | | | |
| **ARE YOU NOW USING EAR PROTECTION?** | | | | | | | | | | | **YES, TYPE USED** | | |  | | | | | | | | | | **NO (IF NO, EXPLAIN BRIEFLY)** | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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