

**San Francisco State University
Communicative Disorders—Audiology Clinic
Hearing Conservation Program (HC-01)**

CLIENT HISTORY

Employee number _____
 Name (last) _____ (first) _____ Date _____
 Work location _____ Extension _____
 Birthdate _____ Age _____

EMPLOYMENT HISTORY

Current Employer _____ Years of Service _____
 Duties _____
 Noise Exposure? Yes, No Hearing Protection? Yes No

MILITARY EXPERIENCE

Have you ever served in the military or an equivalent service? Yes No
 If Yes, were you exposed to noise beyond your basic training? Yes No
 Please explain _____

MEDICAL HISTORY

Have you ever had any of the following? If yes, which ear?

Yes	No		Left	Right	Both	Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Ear surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mumps, Scarlet fever, Measles
<input type="checkbox"/>	<input type="checkbox"/>	Ear injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems
<input type="checkbox"/>	<input type="checkbox"/>	Earaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Ear infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Ringing ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head injuries
<input type="checkbox"/>	<input type="checkbox"/>	Ear pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High fever diseases
						<input type="checkbox"/>	<input type="checkbox"/>	Dizziness

NON-OCCUPATIONAL NOISE EXPERIENCE

Have you ever had routine exposure to any of the following non-occupational noise sources?

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Motorcycles	<input type="checkbox"/>	<input type="checkbox"/>	Trap, Skeet or Target Shooting
<input type="checkbox"/>	<input type="checkbox"/>	Power Tools	<input type="checkbox"/>	<input type="checkbox"/>	Music (Drums, rock & Roll)
<input type="checkbox"/>	<input type="checkbox"/>	Chain Saws	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

HEARING FUNCTION

	Yes	No
Have you seen a doctor about your ears in the past year?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever seen a doctor about your ears?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had your hearing tested before?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have trouble understanding certain words?	<input type="checkbox"/>	<input type="checkbox"/>
Does any member of your family have a hearing loss?	<input type="checkbox"/>	<input type="checkbox"/>

How would you evaluate your own hearing? Good Fair Poor
 In which ear is your hearing best? Left Right Same

Have you been exposed to loud noise within the last 14 hours? Yes No
If yes, did you wear ear protection? Yes No

Employee Signature

Date

Interviewer's Remarks

Interviewer's Signature

Date