Strive 4 life, LLC
902 East 1st Street
Merrill, WI 54452

Phone: 715-201-9600
Fax: 715-722-0155
Email: info@strive-4-life.com

Audiology Questionnaire

Name: _____ Employer: _____

Birth Date: _____ Date of Employment: _____

SSN: _____ Today's Date: _____

Please Answer:

Has it been greater than 14 hours since last exposure to loud noise?	Yes ___No ___
Have you recently experienced pain in either ear?	Yes ___ No ___ Right ___ Left ___ Both ___
Have you recently experienced a draining ear?	Yes ___ No ___ Right ___ Left ___ Both ___
Have you recently experienced dizziness (vertigo)?	Yes ___ No ___ Right ___ Left ___ Both ___
Have you recently experienced severe tinnitus (ringing)?	Yes ___ No ___ Right ___ Left ___ Both ___
Have you recently experienced sudden hearing loss?	Yes ___ No ___ Right ___ Left ___ Both ___
Have you recently experienced fluctuating hearing loss?	Yes ___ No ___ Right ___ Left ___ Both ___
Have you recently experienced ear fullness or discomfort?	Yes ___ No ___ Right ___ Left ___ Both ___
Have you recently had problems wearing hearing protection?	Yes ___ No ___ Right ___ Left ___ Both ___
Have you ever had a severe head injury?	Yes ___ No ___
Do you have frequent ear infections?	Yes ___ No ___ Right ___ Left ___ Both ___
Have you ever been to an ear specialist?	Yes ___ No ___
Have you ever had ear surgery recommended or performed?	Yes ___ No ___
Have you ever had kidney disease?	Yes ___ No ___
Have you ever had scarlet fever?	Yes ___ No ___
Have you ever had meningitis?	Yes ___ No ___
Do you have diabetes?	Yes ___ No ___
Do you have high blood pressure?	Yes ___ No ___
Do you have existing hearing problems?	Yes ___ No ___
Do you currently use prescription or over-the-counter drugs?	Yes ___ No ___
Are you currently suffering from a cold, flu or allergies?	Yes ___ No ___
Do you shoot guns or hunt currently or ever?	Yes ___ No ___
Do you operate farm equipment or drive with window(s) down?	Yes ___ No ___
Do you participate in loud activities (music, motorcycle)?	Yes ___ No ___
Do you operate chain saws or power tools?	Yes ___ No ___
Does any of your immediate family have hearing problems?	Yes ___ No ___
Do you wear hearing aids?	Yes ___ No ___

Examiner Only:

Subject has visible wax or object in ear	Yes ___ No ___
Subject should be referred	Yes ___ No ___

_____ _____ _____ _____

Examiner Date Participant Date

Medical Examiner Comments: _____

_____

_____

_____

_____