



AUDIOMETRY QUESTIONNAIRE.

Company:
Job Title:

PERSONAL DETAILS

Surname:			
First Name(s):			
D.O.B:			
Address:			
	Y	N	If yes please give details
Do you wear a hearing aid?			
Have you had an injury to your ears?			
Have you had any operations on your ears or a perforated ear drum?			
Have you ever had an injury to the head that made you unconscious?			
Do you suffer with ringing noises in your ears or head?			
Have you suffered from earache, discharging ears or other ear disease as a child or adult?			
Do you suffer from or have you suffered from giddiness or dizziness?			
Have you ever had exposure to ototoxic drugs or solvents? E.g. streptomycin, otosporin, quinine?			
Do you suffer from wax in your ears? If so have you had this syringed?			
Is there any ear disease or deafness in your family?			
Have you had exposure to gunfire/blasts/explosions?			

Do you have any noisy hobbies such as motor sports, attending clubs or discos, shooting, playing in a band etc?			
Have you ever had Meningitis or Tuberculosis?			

Do you currently have to shout to make yourself heard at work?

All the time Half the time Occasionally Never

Do you consider your hearing to be: Left Ear Good/ Fair/ Poor Right Ear Good/ Fair/ Poor

Have you been exposed to noise in previous jobs? If yes please give details:

Employer	Role	Length of exposure	Hearing protection worn?

Current Employment:

Is your current work noisy?	YES (Intermittent) (Constant)	No
Do you use hearing protection?	YES (Ear plugs) (Ear Defenders)	No
Have you been at work (or exposed to noise) today?	YES (for how long)	No

Under GDPR 2018, health data is processed under Article 9 (2) (h): processing is necessary for the purposes of preventive or occupational medicine, for the assessment of the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems or services.

I consent to undergo health surveillance as described/explained to me.

I give my consent for the Occupational Health Nurse to discuss the outcome of my medical assessment with my manager if in his/her professional opinion this outcome could affect fitness for work or personal safety.

I understand that the result will be included in my Occupational Health records, as part of health surveillance requirements under the COSHH (2002) Regulations:

Failure to sign the consent may result in Health Surveillance not being undertaken by the OH Nurse and your manager will be advised of this. All medical information is kept in medical confidence and no clinical information is given to your employer. You are entitled to copies of your health records and if you wish a copy please apply in writing to South Glos Occupational Health Ltd. No personal information is shared with third parties and that information is kept in confidence in our records.

I declare that the information given above, is true and accurate, to the best of my knowledge.

Signature of employee:	Print name:
Date:	

FOR OH NURSE COMPLETION ONLY

Ear Examination

On examination were the eardrums seen and intact?	Left	Yes/No	Comments:
	Right	Yes/No	
Was more than 50% of the tympanic membrane visible?	Left	Yes/No	Comments:
	Right	Yes/No	

Comments: (audio booth / background noise etc.)

Category:	
Outcome:	
Advice given to client:	
Signature of OHA:	Print name:
Date:	