Primary Care Medical Center, PLLC

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AUDIO QUESTIONNAIRE

Company Name								Social Security Number						
Name				Date of Birth				Sex					Date of Exam	
Cal Date	Right Ear							Left Ear						
	500	1000	2000	3000	4000	6000	8000	500	1000	2000	3000	4000	6000	8000

Any history of hearing loss?
Ear infections or running ears?
Ear pain?
Ringing in the ears?
Dizziness?
Drugs (esp. Streptomycin, aspirin, quinine)?
Any known ear damage?
Any previous hearing tests? ☐ **Y** ☐ **N** When?
Where?
Why? Doctor's Name?
Hearing loss in family?
Previous noise exposure? Military?
Sports (hunting, pistols, etc.)
Loud music?
Prior occupation?
Other: