U.S. DEPARTMENT OF COMMERCE
National Oceanic and Atmospheric Administration

Audiology History Questionnaire

Hearing Conversion Program (HCP) Audiograms Only

1. LAST NAME, FIRST NAME, MIDDLE INITIAL	2. SSN	3. STATUS:

Answer with a YES/NO if statement applies to you:

5. In the last year have you experienced:	Yes	No			
Difficulty understanding speech:					
A. Under all circumstances:					
B. In background noise					
C. On telephone:					
Ringing in ears:					
A. Constant:					
B. Intermittent:					
C. High-pitched ring:					
D. Low-pitched buzz					
Dizzy spells (spinning)					
Presence or persistence of ear pain:					
Rapidly progressing hearing loss					
feeling of fullness or discomfort in either ear:					
6. History of:					
Chronic ear infections					
Eardrum rupture					
Sudden or fluctuating hearing loss					
Ear Surgery					
Skull facture					
Taking drugs that affect hearing					
Hearing aid use					
Poor hearing in one ear					
Chronic exposure to loud noise without protection:					
Relevant medical problems					
7. Recreational noise exposure:					
Firearm use (hunting, target shooting etc.)					
Drag racing/motorcycle racing					
Power tool use (routers, saws etc.)					
Amplified music(concerts):					
Walk man/headset use					
Other high noise exposure					
Do you wear hearing protection, both on and off the job, When appropriate?					

Provide information to (YES) statements on SF-600

Medical Officer Review (initials): 8. NAME 9. INITIAL

Reset Form