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| Title: Mr/ Mrs/ Miss/ Ms/ Prof/ Dr: |
| Surname: |
| First Names: |
| Address: |
| Post Code: |
| Date of Birth: |
| Job Title: |
| Department & Contact Telephone Number: |
| Name of Line Manager/ Supervisor: |
| Date Commenced Post: |

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| **Employment History:** | **(Please ✓ as appropriate)** | **YES** | **NO** |
| Have you ever been employed in a previous role where you were exposed to excessive noise? | |  |  |
| If **‘YES’** what type of industry and/ or work were you involved in? | | | |
| If **‘YES’** were you offered hearing protection? | |  |  |
| If **‘YES’** did you wear hearing protection? | |  |  |
| If **‘YES’** can you provide dates of when you worked in a noisy environment? | |  |  |
| These dates are:- | | | |
| Have you ever had a hearing test in the past? | |  |  |
| If **‘YES’** when did this hearing test take place? | | | |
| What was the result of this hearing test? | | | |

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| **Current Employment:** | | | **(Please ✓ as appropriate)** | | | | **YES** | **NO** | **UNSURE** |
| Does your job require you to wear hearing protection? | | | | | | |  |  |  |
| If **‘YES’** haveyou been offered hearing protection? | | | | | | |  |  |  |
| If **‘YES’** how often did you use hearing protection? | | | | | | |  |  |  |
| **Rarely** |  | **Occasionally** | |  | **Frequently** |  | **Always** | |  |
| Have you been instructed in the use and maintenance of your hearing protection? | | | | | | |  |  |  |
| What type of hearing protection have you been issued with? | | | | | | | | | |
| Do you use hearing protection in designated areas only? | | | | | | |  |  |  |
| Where were you last exposed to loud noise? (Please provide date and time) | | | | | | | | | |

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| **About you…** | | | | | | |  | | | | | | | | **YES** | **NO** |
| Do you consider your hearing to be: | | | | | | | | | | | | | | |  |  |
| **Good** | | |  | | | **Fair** | | | |  | | | **Poor** | |  | |
| Have you noticed any recent changes in your hearing? | | | | | | | | | | | | | | |  |  |
| If **‘YES’** which ear is affected? Right Left Both | | | | | | | | | | | | | | |  |  |
| Do you have difficulty in deciding where sounds come from? | | | | | | | | | | | | | | |  |  |
| Have you had any ear operations, ear infections or a disease that has affected your hearing in the past? | | | | | | | | | | | | | | |  |  |
| Have you ever seen your General Practitioner with ear problems or hearing difficulty? | | | | | | | | | | | | | | |  |  |
| Do you suffer with ringing in your ears, face numbness, dizziness or vertigo? | | | | | | | | | | | | | | |  |  |
| Do you suffer from excessive ear wax? | | | | | | | | | | | | | | |  |  |
| Have you ever had a perforated eardrum? | | | | | | | | | | | | | | |  |  |
| Have you ever suffered with concussion, a head injury or an ear injury? | | | | | | | | | | | | | | |  |  |
| Do you suffer with high blood pressure? | | | | | | | | | | | | | | |  |  |
| Have you suffered with any of the following diseases? **Please ✓ as appropriate.** | | | | | | | | | | | | | | | | |
| Measles |  | | | Mumps | | | |  | Chicken Pox | | |  | | Scarlet Fever |  | |
| Diphtheria |  | | | Malaria | | | |  | Tuberculosis | | |  | |  |  | |
| Have you ever taken the drug Streptomycin? | | | | | | | | | | | | | | |  |  |
| Do you wear a hearing aid? | | | | | | | | | | | | | | |  |  |
| Are you aware of any family history of hearing loss prior to the age of 50 years old? | | | | | | | | | | | | | | |  |  |
| Have you, or do you, regularly participate in any of the following activities? **Please ✓ as appropriate.** | | | | | | | | | | | | | | | | |
| Shooting | |  | | | Pop concerts/ disco’s or clubs: | | | | | |  | Listening to loud music | | | |  |
| Motor Sport | |  | | | Playing a musical instrument | | | | | |  | DIY (use of power tools) | | | |  |
| Using power tools or farm machinery | | | | | | | | | | |  | Mobile phone (which ear) | | | |  |
| Other: (Please give details): | | | | | | | | | | | | | | | | |
| Have you ever been involved with any of the military services either as a regular, cadet or a member of the Territorial Army? | | | | | | | | | | | | | | |  |  |
| If **‘YES’** state which and for how long? | | | | | | | | | | | | | | | | |
| Have you had a gold or sinusitis in the last week? | | | | | | | | | | | | | | |  |  |
| Are you currently taking medication? | | | | | | | | | | | | | | |  |  |
| If **‘YES’** what is the name of the medication you are taking? | | | | | | | | | | | | | | | | |
| Are there any other details about your hearing which you may feel is relevant which we have not asked you about? | | | | | | | | | | | | | | |  |  |
| If **‘YES’** please detail below:- | | | | | | | | | | | | | | | | |

The information supplied by you on this questionnaire will be used to produce a Hearing Category Certificate. This will be forwarded to your line manager/supervisor as evidence of your fitness to work/study.

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| Name: | Signature: | Date: |