PLEASE CHECK YES OR NO TO THE FOLLOWING QUESTIONS

1. Do you have a hearing problem? ................................................................. □ Yes □ No
2. Have you ever had a hearing test? .............................................................. □ Yes □ No
3. Have you ever been told you have a hearing loss? ................................. □ Yes □ No
4. Have you ever worked in a noisy environment? ....................................... □ Yes □ No
5. Have you been exposed to gunfire or explosions? .................................. □ Yes □ No
6. Is anyone in your family hard of hearing? ............................................... □ Yes □ No
7. Do you wear hearing protection regularly? .............................................. □ Yes □ No
8. Have you worn hearing protection today? ................................................ □ Yes □ No
9. Repeated noise exposures (check all that apply):
   □ loud noises  □ power tools  □ hammering  □ auto body repair
   □ chain saws  □ motorcycles  □ fireworks
   □ other:

10. Rate your hearing:        □ good   □ fair    □ poor    □ don't know
    □ better with left ear  □ better with right ear

11. Have you ever had any of the following problems? (check all that apply)
    □ Ear infections     □ Dizziness     □ Ear injury     □ Draining/Running
    □ Ear surgery       □ Ringing       □ Hearing loss   □ Mastoid problems
    □ Wax blockage      □ Ear pain      □ Head injury    □ Punctured eardrum
    □ Hearing better on certain days □ Feeling pressure/fullness in ears
    □ Hearing problems of any kind, (describe): ____________________________

12. Has there been any change in your hearing during the past year? □ Yes □ No
    Describe: __________________________________________________________

DATE: ___________________________ SIGNATURE: _________________________

NOISE DOSE: _______________________

*NU3708*