

MID-STATE

Occupational Health Services, Inc.

NAME _____ COMPANY _____
SOC. SEC. # _____ CONTACT _____
DATE OF BIRTH _____ SEX _____ TEL NO. _____
SERVICE DATE _____ DATE OF INTERVIEW _____
NAME OF INTERVIEWER _____ TEL NO. OF INTERVIEWER _____

This form should be completed by the interview with the employee. All information is kept strictly confidential.

EXTENDED QUESTIONNAIRE

The TWA notation will be very helpful to Dr. Conly in making a determination regarding Logging on OSHA 300.

Work History: On the job Noise Exposure Levels (Please offer exact levels if possible)

1. Noise Level _____ dBA TWA*
2. In the past 2 years, has your job gotten noisier? No _____ Yes _____
3. Job Title _____
4. Type of Hearing Protection _____

Non-Occupational History (Mark Any That Apply)

***H.P = HEARING PROTECTION**

Activity	Years of Use	Hours/Month	Use of H.P.*
Wood Working			
Metal Working			
Go-Carts/Auto Race			
Outboard Motors			
Motorcycles			
Farm Machinery			
Stereo Headphones			
Airplane Pilot			
Chain Saws			
Grinders/Chippers			
Air-driven Tools			
Explosive Tools			
Gas Lawn Mowers / Leaf Blowers			
Gas Weed Whackers			
Loud Music			
Snow Mobiles			
Boat/Jet Skis			
Heavy Equipment			

Activity	# of years	Caliber of weapon	# of rounds/year	H.P.*
Hunting				
Skeet Shooting				
Rifle Shooting				
Pistol Shooting				

Which Shoulder if rifle or shotgun? R _____ L _____

When did you first notice a change in your hearing? _____

Has your hearing gotten worse during the past few years? No _____ Yes _____

GENERAL HEALTH

1. Do you have any of the following?

- High Blood Pressure _____
- Diabetes _____
- Sinusitis _____
- Family Hearing Loss _____
- Meniere's Disease _____
- Viral Infections _____

Dizzy Spells: Occasional (once or twice a year) _____
 Frequent (once or twice a month) _____
 Very frequent (once or twice a week) _____

	Right	Left	Both
Ear Problems:	_____	_____	_____
Earaches	_____	_____	_____
Discharge from ears	_____	_____	_____
Ringing or Noises	_____	_____	_____
Other _____			

2. Have you seen a doctor for your problem? No _____ Yes _____ Diagnosis _____

3. Have you had ear surgery? No _____ Yes _____ Year _____

4. Type of surgery? _____

5. Have you ever had any of the following medications in the past (2) years?

- Streptomycin No _____ Yes _____
- Neomycin No _____ Yes _____
- Kanamycin No _____ Yes _____
- Quinine No _____ Yes _____
- Large amounts of aspirin No _____ Yes _____
- Diuretics No _____ Yes _____

Comments: _____

Employee Signature _____ Date _____

E.Q. Result

_____ Log on OSHA Form 300 _____ OSHA STS Repealed

_____ Do Not Log on OSHA Form 300 _____ No Further Action

_____ Other _____

Consultant Signature _____ Date _____