WHARFEDALE
Occupational Health Services

hands on Occupational Health

Name:…… Date of Birth:……

Occupation:…… Date: ……..

Has your hearing changed since your last hearing test?	Yes/No			
Since your last test is your hearing	Same		Better	Worse
What type of hearing protection do you use?	Muffs		Plugs	Both
How often do you use it?	Always	Usually	Sometimes	Rarely
Have you had any injuries or operations that have affected your ease since your last test?	Yes/No			
Since your last test have you been				
Knocked unconscious	Yes/No			
In close proximity to an explosion	Yes/No			
Started any noisy hobbies	Yes/No			
Have you been in noise today?	Yes/No			
How long?	……hours……minutes			
Have you worn hearing protection today?	Yes/No Type Used……..			

I have been instructed in the importance of protecting my hearing, care and use of hearing protection in the past.

I *agree/*do not agree to the results of my audiogram including HSE category being communciated to my manager and the health and safety officer in the interests of protecting my hearing.
(*delete as applicable)

Signed……Print Name ……Date……..

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Occupational Health Use Only: OH advisor……

Ear	Canal			Tympanic Membrane				
	Wax	Appears normal	abnormalities	Appears Normal	Scarring	Perforation	Partially seen	Not seen
Left								
Right								