



UF Hearing Program / Annual Medical Update Form		
<b>Employee Information</b>		
Name:	Date of Birth:	
UF ID:	Position (Title):	
Supervisor:	Department:	
Work Phone Number:	Work Address: (if located off-campus, provide name of center only)	
<b>Hearing Protection Device (HPD) Use</b>		
Last date of HPD Training	_____	
dBA 8-hour TWA Noise Exposure Level	_____	
Do you use a hearing aid?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Hearing Test Information</b>		
Frequent or severe dizziness:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Frequent allergy problems:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cold or flu in the last two weeks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any ringing in your ears?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any family member with hearing loss before age 50:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you currently under physicians care for ear problem(s):	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any antibiotics or medication in the last month:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any previous ear surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Current ear ache, ear infections or drainage in:	<input type="checkbox"/> Left	<input type="checkbox"/> Right
Past ear ache, ear infections or ear drainage in:	<input type="checkbox"/> Left	<input type="checkbox"/> Right
Any exposure to loud explosions	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any head injury causing unconsciousness:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a second job that is noisy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Last Exposure to noise	_____	
Do you listen to loud music or play in a band?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Worked at a noisy job previously:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Firearms use: Sport or Military:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you use power-driven farm or construction equipment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any noisy hobbies? (motorcycles, power tools)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had:	<input type="checkbox"/> Measles <input type="checkbox"/> Mumps <input type="checkbox"/> Diabetes	<input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Meningitis <input type="checkbox"/> High Blood Pressure
Employee's Signature:	Date:	