NOISE AND AUDIOMETRIC SURVEILLANCE QUESTIONNAIRE

The purpose of the questionnaire is to assess whether you have any health problems that may affect your ability to undertake the duties of your role or place you at any risk in the workplace. OHS will make recommendations to the University regarding adjustments or modifications required to your role as a result of this assessment. Our aim is to promote and maintain the health of all people at work.

Full Name:			DOE	3 & Age:			
Place of Work:			Осс	upation	:		
(School & Dept)				•			
` ' '							
Birth Gender		Date & Time:					
Male / Female:							
l amouth of							
Length of		Line Manag			jer:		
Employment:							
	1	\/=c	_	NO		D ("	
	nditions	YES	5	NO		Details	
Have you had ear troub							
	Infection						
	Discharge Wax						
	Deafness						
	Injury						
	Operation						
Is there a history of dea	•						
Have you suffered any	of the following?						
Measles							
	Mumps						
Chicken Pox							
Scarlet Fever							
Meningitis							
	Diphtheria						
Head injury							
Do you suffer from noises in your head or ears?							
Do you suffer from dizzi	iness?						
bo you canor nom alzzi							
Do you take any medica	ation?						
Do you have a hobby that involves noise?							
Have you been exposed to gunfire as a hobby or professionally?							
Do you regularly attend pubs / clubs or use a							
personal music device with head/earphones							
Have you been expos							
the last 48 hours?							
Have you had a hearing							
		l	1				

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Н	ave you worl	ked in noisy	jobs in the pa	ast?							
Conditions				YES	NO		Details				
Have you worn hearing protection in the last year?											
L	ast exposure	to noise?			<u> </u>						
٧	/as hearing p	protection wo	orn?								
Ear Examination: L: R:											
		4.0.4	2 . 4 . 6		4			4 . 0 . 2 . 4			
	kHz	1+2+,	3 + 4 + 6	Current	4 + 6 t/<3 years ifference?		1 + 2 + 3 + 4				
	Ear	L	R	L	R		L	R			
	Sum										
	Category										
	Action										
Comments:											
Assessment: (please circle outcome)											
FIT for specified work FIT w			FIT with res	trictions		REF	REFERRED for medical opinion				
OH signature:						Date:					
All employees have the right to access their Occupational Health records. Should you wish to do so, please speak to a member of the Occupational Health team for more details.											
I hereby declare that the above medical information is true and accurate to the best of my belief and knowledge. I will notify Occupational Health if there is any change to my health.											
Employee signature: Date:											

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