Mail completed forms to:
Department of Labor and Industries
PO Box 44291
Olympia WA 98504-4291

Occupational Hearing Loss Questionnaire

Name	Claim Number	Injury Date

1. When did you first notice your hearing loss?

2. Was the onset of the hearing loss:
☐ Sudden ☐ Gradual

3. What kind(s) of hearing problems are you having? (Circle letter of all applicable items.)

A. Ringing in ears.
B. Difficulty hearing on the phone.
C. Difficulty hearing spoken communication in one-on-one conversation.
D. Difficulty understanding spoken communication in the presence of surrounding noise.
E. Other – explain:

4. While employed, did your hearing loss interfere with your work?

☐ No

☐ Yes – explain below:

5. Name and address of doctor who told you your hearing loss was occupational?

Name

Address

City State Zip Code

6. How were you notified?

☐ Written (please attach a copy)

☐ Oral

☐ Other – explain below:

7. Have you been examined by any other doctor in the past for hearing loss:

☐ No
☐ Yes – please provide:

Doctor's Name

Address

City State Zip Code

Exam Date Audiogram Done? ☐ No ☐ Yes

Doctor's Name

Address

City State Zip Code

Exam Date Audiogram Done? ☐ No ☐ Yes

8. When you were first told by a doctor that your hearing loss was caused by work noise, did he/she also tell you that you should have:

A. Medical Treatment – ☐ No ☐ Yes – explain below:

B. A hearing aid – ☐ No ☐ Yes

C. Did you have an audiogram? ☐ No ☐ Yes

9. Have you ever had hearing aids in the past?

☐ No
☐ Yes – please provide:

Doctor's Name/Clinic Name

Address

City State Zip Code

10. Do you have a health problem for which you must take medication on a regular basis?
☐ No ☐ Yes – explain the health problem and what kind of medication you are taking below:

11. Name and address of doctor prescribing your medications:

Doctor's Name

Address

City State Zip Code

12. Have you had any injury to your ear(s)?

☐ No

☐ Yes – explain below:

13. Have you had any illness that affected your ears or hearing?
☐ No
☐ Yes – indicate when and name of illness:

14 Have you ever had a head injury?
☐ No
☐ Yes – describe the injury below:

15. Have you had any illness involving high fever?
☐ No
☐ Yes – indicate when and name of illness:

16. Have any members of your family suffered hearing loss?
☐ No
☐ Yes – specify relationship (mother, father, uncle, etc):

17. Were you a member of a union or trade when exposed to the noise that you think contributed to your hearing loss?
☐ No
☐ Yes – which union?

18. Do you have any hobbies of non-work activities which involved loud noise such as: (check all that apply)

☐ Loud Music
☐ Auto Repair
☐ Woodworking
☐ Metal Working
☐ Wood Cutting
☐ Snowmobiling
☐ Motorbiking
☐ Boating
☐ Hunting/Target Practicing
☐ Auto Racing
☐ Flying Aircraft
☐ Operating Noisy Equipment such as:
  ☐ Tractors
  ☐ Farm Equipment
  ☐ Lawn Mowers
☐ Other – please specify:

19. Type of equipment or tools used for hobbies:	How Often?	How Long (time/duration)?

Please list any hobbies or activities you participate in that involve noise?

20. Current or last rate of pay:
Amount:
$
Rate of pay:
☐ Hour ☐ Day ☐ Week ☐ Month

21. Are you retired?
☐ No
☐ Yes

21A. If you're retired, why did you retire?

21B. If you're retired, what is the last date you worked when you were exposed to noise that you think contributed to your hearing loss? (Give the month and year.)

21C. Did you have a hearing test as any part of a physical exam when you retired?
☐ No
☐ Yes

22. Was your employer contributing to your and/or your family's medical dental, and/or vision insurance on the last day you worked when exposed to noise that you think contributed to your hearing loss?
☐ No
☐ Yes

Date

Signature