# UF Hearing Program / Annual Medical Update Form

## Employee Information

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date of Birth:</th>
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<tbody>
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<table>
<thead>
<tr>
<th>UF ID:</th>
<th>Position (Title):</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Supervisor:</th>
<th>Department:</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Work Phone Number:</th>
<th>Work Address: (if located off-campus, provide name of center only)</th>
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</table>

## Hearing Protection Device (HPD) Use

<table>
<thead>
<tr>
<th>Last date of HPD Training</th>
<th>dBA 8-hour TWA Noise Exposure Level</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

## Do you use a hearing aid?  
- [ ] Yes  
- [ ] No

## Hearing Test Information

- Frequent or severe dizziness:  
  - [ ] Yes  
  - [ ] No

- Frequent allergy problems:  
  - [ ] Yes  
  - [ ] No

- Cold or flu in the last two weeks?  
  - [ ] Yes  
  - [ ] No

- Any ringing in your ears?  
  - [ ] Yes  
  - [ ] No

- Any family member with hearing loss before age 50:  
  - [ ] Yes  
  - [ ] No

- Are you currently under physicians care for ear problem(s):  
  - [ ] Yes  
  - [ ] No

- Any antibiotics or medication in the last month:  
  - [ ] Yes  
  - [ ] No

- Any previous ear surgery:  
  - [ ] Yes  
  - [ ] No

- Current ear ache, ear infections or drainage in:  
  - [ ] Left  
  - [ ] Right

- Past ear ache, ear infections or ear drainage in:  
  - [ ] Left  
  - [ ] Right

- Any exposure to loud explosions:  
  - [ ] Yes  
  - [ ] No

- Any head injury causing unconsciousness:  
  - [ ] Yes  
  - [ ] No

- Do you have a second job that is noisy?  
  - [ ] Yes  
  - [ ] No

## Last Exposure to noise

<table>
<thead>
<tr>
<th>Do you listen to loud music or play in a band?</th>
<th>Worked at a noisy job previously:</th>
<th>Firearms use: Sport or Military:</th>
<th>Do you use power-driven farm or construction equipment?</th>
<th>Any noisy hobbies? (motorcycles, power tools)</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Yes</td>
<td>[ ] Yes</td>
<td>[ ] Yes</td>
<td>[ ] Yes</td>
<td>[ ] Yes</td>
</tr>
<tr>
<td>[ ] No</td>
<td>[ ] No</td>
<td>[ ] No</td>
<td>[ ] No</td>
<td>[ ] No</td>
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</tbody>
</table>

## Have you ever had:

- [ ] Measles  
- [ ] Mumps  
- [ ] Diabetes  
- [ ] Scarlet Fever  
- [ ] Meningitis  
- [ ] High Blood Pressure

<table>
<thead>
<tr>
<th>Employee's Signature:</th>
<th>Date:</th>
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Revision Date: 02/2014