

Initial Noise Health Surveillance Questionnaire

PART 1

Surname:	Mr/Mrs/Miss/Ms/Dr/Prof/Other:
First names:	Date of Birth:
Job title:	Supervisor:
Department:	Work tel:
Start Date:	Email:
Status:	Research staff/Technical staff/Undergraduate/Postgraduate/Academic Visitor/Other
GP Surgery:	

Under the Noise at Work Regulations (2005), Occupational Health (OH) undertake health surveillance for all University Staff that, following risk assessment, have been identified as likely to be regularly exposed to noise above the Upper Exposure Action Value (EAV) of 85db and/or where exposure is between the lower (80db) and upper EAV if the individual has been identified as particularly sensitive to noise/NIHL and therefore registered on our health surveillance programme.

Data Protection Information

The information that you supply on this questionnaire will be held in confidence by the University Occupational Health Service as part of your occupational health record. For full details of how your personal information is used by the University Occupational Health Service, please see <http://www.oh.admin.cam.ac.uk/general-information/confidentiality-statement>

A) Medical History

Do you consider your hearing to be?

Left ear

Good / Fair / Poor

Right ear

Good / Fair / Poor

(Please circle Yes or No) Please provide details if answer is yes

Do you wear a hearing aid?	Yes	No
Have you ever suffered any injury or trauma to your ears?	Yes	No
Have you suffered earache, discharging ears or other ear disease as a child or adult?	Yes	No
Is there any ear disease or deafness in your family?	Yes	No
Have you ever suffered head injury / concussion / unconsciousness?	Yes	No
Do you or have you ever had ringing / buzzing / noise (tinnitus) in your ear / head?	Yes	No
Do you suffer from dizziness / giddiness?	Yes	No
Do you or have you ever had any exposure to ototoxic drugs or solvents e.g. Streptomycin, Otosporin, Quinine, Tolene?	Yes	No
Do you or have you ever had any exposure to gunfire/blasts/explosions (past or present)?	Yes	No
Do you have any noisy hobbies e.g. motor sports/motorcycle riding/DIY/discos/concerts/loud music/shooting/other? (If yes, frequency/duration?)	Yes	No
Have you ever had wax removed from your ears? When was the last time?	Yes	No

Do you hear better or worse in noise? Better/Worse (please circle)	Yes	No
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B) Current noise exposure (please circle the answer where applicable)

Does your job expose you to high levels of noise?	Yes	No
Please list noisy equipment/machinery to which you are exposed and give details of dB level if known		
How many hours per day are you exposed to noise (if your job is very varied consider how many hours per week?		
Do you have to shout to make yourself heard at a distance of 10 feet/3 meters away?	Yes	No
During your routine work is hearing protection Optional/Compulsory (please circle)		
Do you wear hearing protection? If yes, what do you wear? Please list e.g. ear plugs / ear defenders	Yes	No
If hearing protection is compulsory, do you wear it always/sometimes/never? (Please circle)		
Have you been exposed to noise within the last 48 hours? If yes, give details	Yes	No
Did you wear hearing protection before your hearing test? If yes, give details	Yes	No

C) Previous noise exposure

Include past noisy jobs where you have had to shout to be heard. **(Please circle Yes/No)**

Company:	Job:	Dates:
Ear protection provided?	Yes No	Details
Ear protection worn?	Yes No	Sometimes?
Health Surveillance?	Yes No	
Company:	Job:	Dates:
Ear protection provided?	Yes No	Details
Ear protection worn?	Yes No	Sometimes?
Health Surveillance?	Yes No	
Company:	Job:	Dates:
Ear protection provided?	Yes No	Details
Ear protection worn?	Yes No	Sometimes?
Health Surveillance?	Yes No	
Company:	Job:	Dates:
Ear protection provided?	Yes No	Details
Ear protection worn?	Yes No	Sometimes?
Health Surveillance?	Yes No	

Please continue on a separate sheet if necessary

Part 2 – For OH Use (Initial Noise Health Surveillance Questionnaire)**Name:****DOB:****Date:****Time:****Otoscopic Examination (Please circle Yes or No)**

Wax in auditory canal?	Left: Yes / No	Right: Yes / No
(<50% of tympanic membrane visible)	Left: Yes / No	Right: Yes / No
Exudate in auditory canal?	Left: Yes /No	Right: Yes /No
Tympanic membrane	Left: normal scarred perforated not visible	
	Right: normal scarred perforated not visible	
Comments:		

Results:

KHz	1+2+3+4+6		Within 3 years 3+4+6 >30dB (RHL)				1+2+3+4 >40dB (UHL)	
Ear	L	R	L		R		L	R
Sum			current	Previous <3yrs	current	Previous <3yrs		
Cat.								
Result								
Action								

Advice given to individual: (Please circle)

	Yes	No	Comments
Within normal limit	Yes	No	
OHT/CN/OHA to discuss with OHM/OHP	Yes	No	
Advised to see GP	Yes	No	
For wax removal/information provided	Yes	No	
Wear hearing protection	Yes	No	
HSE Noise (INDG363(rev2) leaflet given	Yes	No	
Copy of hearing test given to individual	Yes	No	

Outcome: (Please circle)

	Yes	No	Comments
Repeat test	Yes	No	
OHP appointment	Yes	No	
Annual Surveillance	Yes	No	
Annual Enhanced Surveillance	Yes	No	
3 yearly surveillance	Yes	No	
Letter code			
Date next surveillance due:			

In accordance with the Control of Noise at Work Regulations 2005, a noise risk assessment has been performed and health surveillance deemed necessary to monitor hearing. I understand that the noise health surveillance questionnaire and hearing tests are part of a hearing conservation programme and I consent to my supervisor/DSO being informed of the overall results of my hearing tests.

Employee signature:**Date:****OHT/CN/OHA signature:****Stamp:**

Name:..... DOB:.....

Comments:

Date and time	
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