Hearing History Questionnaire

(Please print. All information must be completed.)

Today's Date: _____ **Company:**_____

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Date of Birth: _____ **Sex:** **Male** **or** **Female**

1) Do you use any of the following Hearing Protection when in noise?

a) Ear Plugs: Yes ☐ No ☐ % of time used when required: _____%
b) Ear Muffs: Yes ☐ No ☐ % of time used when required: _____%
c) Canal Caps: Yes ☐ No ☐ % of time used when required: _____%
d) Combination: Yes ☐ No ☐ % of time used when required: _____%

2) Last date of Hearing Protection Device training: _____/_____/_____ a) No training received: _____

3) 8-hour time weighted average noise exposure level: _____

4) When was your last exposure to noise? _____

5) Do you have a family member who had hearing loss before age 50? Yes ☐ No ☐

6) Do you have difficulty hearing? Yes ☐ No ☐

a) If yes, in which ear? Rt ☐ Lt: ☐ Both: ☐

7) Do you wear a hearing aid? Yes ☐ No ☐

8) Do you have ringing in your ears? Yes ☐ No ☐

9) Do you have frequent allergy problems? Yes ☐ No ☐

10) Do you experience frequent or severe dizziness? Yes ☐ No ☐

11) Have you had a cold or the flu in the last two weeks? Yes ☐ No ☐

12) Have you ever had measles? Yes ☐ No ☐

13) Have you ever had scarlet fever? Yes ☐ No ☐

14) Have you ever had diabetes? Yes ☐ No ☐

15) Have you ever had mumps? Yes ☐ No ☐

16) Have you ever had meningitis? Yes ☐ No ☐

17) Have you ever had high blood pressure? Yes ☐ No ☐

18) Have you taken any medications or antibiotics in the last month? Yes ☐ No ☐

a) If yes, what? _____

19) Have you had an ear infection, ear drainage, or an earache within the last month? Yes ☐ No ☐

20) Are you under a physician's care for ear problems? Yes ☐ No ☐

21) Have you had ear infections, earaches, or ear drainage in the past? Yes ☐ No ☐

TURN OVER ↓

22) Have you previously had ear surgery? Yes ☐ No ☐

a) If yes, which ear? Rt. ☐ Lt. ☐ Both ☐

23) Have you ever been exposed to a loud explosion? Yes ☐ No ☐

24) Have you ever had a head injury that caused unconsciousness? Yes ☐ No ☐

25) Have you ever shot firearms - sport or military? Yes ☐ No ☐

26) Do you listen to loud music or play in a band? Yes ☐ No ☐

27) Do you participate in any loud hobbies (motorcycles, power tools, racing)? Yes ☐ No ☐

28) Have you ever operated power-driven farm equipment? Yes ☐ No ☐

29) Have you ever operated construction equipment? Yes ☐ No ☐

30) Did you work in a noisy environment at any of your previous jobs? Yes ☐ No ☐

31) Do you have a second job that is noisy? Yes ☐ No ☐

Employee Signature: _____ Date: _____

AUDIOMETRIC TEST (To be completed by person administering the test)

Audiometer Make/Model: HT Wizard Serial No.: 01021046

Last electronic calibration: 11/09/2012 Last biological calibration: _____

Was test performed in room which complies with background noise levels in Appendix D of "Audiometer Test Rooms" of Occupational Noise Standard (29 CFR 1910.95)? Yes X No ____

Type of Test: ___ Pre-Hire ___ Annual Surveillance ___ Retest ___ Health Evaluation ___ Other ___ Exit

Hearing Test Data (dB HL)							
Ear	500 Hz	1000Hz	2000Hz	3000Hz	4000Hz	6000Hz	8000Hz
Left							
Right							

EG= Frequency not tested ED= No response at 95dB maximum EF= No threshold clearly established EE= No response at 90dB maximum

***Left Ear Average*: _____ *Right Ear Average*: _____**

Examiner's Signature: _____ Date: _____

Physician's Signature: _____ Date:_____

Comments:_____

_____

St. Joseph Regional Health Center
Bryan, TX

TUBERCULIN SKIN TEST QUESTIONAIRE AND CONSENT

PATIENT NAME: _____

COMPANY / DEPT: _____ WORK PHONE: _____

SUPERVISOR: _____ HOME PHONE: _____

PLEASE ANSWER THE QUESTIONS BELOW:

YES NO **HAVE YOU EVER HAD A POSITIVE TB SKIN TEST** IN THE PAST, HAVE BEEN SENT FOR A CHEST XRAY OR PUT ON MEDICATION BECAUSE OF A TB TEST? IF YES, DATE OF LAST CXR _____

YES NO IN THE PAST 30 DAYS, HAVE YOU BEEN VACCINATED FOR **MMR, POLIO**, **VARICELLA OR YELLOW FEVER**?

YES NO HAVE YOU EVER HAD A BCG VACCINATION? (A VACCINE FOR TUBERCULOSIS, NOT OFFERED IN THE UNITED STATES)

YES NO ARE YOU CURRENTLY PREGNANT OR BREASTFEEDING?

YES NO HAVE YOU RECEIVED **CHEMOTHERAPY** OR **STEROIDS** WITHIN THE LAST 6 WEEKS?

I HAVE ANSWERED THE QUESTIONS ABOVE TO THE BEST OF MY KNOWLEDGE AND GIVE MY CONSENT TO HAVE THE TB SKIN TEST ADMINISTERED.

DATE: _____ SIGNATURE: _____

SIGNATURE OF PARENT/GUARDIAN IF PATIENT IS UNDER 18: _____

TB ADMINISTRATION DOCUMENTATION (*TO BE COMPLETED BY TRAINED PERSONNEL ADMINISTERING TEST)*

TB TEST GIVEN

DATE SKIN TEST APPLIED: _____

TIME APPLIED: _____

ADMINISTERED BY: _____

MANUFACTURER: _____

LOT#: _____ EXP DATE: _____

SITE (FOREARM) (CIRCLE ONE): **R** **L**

TB SKIN TEST INTERPRETATION

DATE OF INTERPRETATION: _____

TIME READ: _____

INTERPRETED BY: _____

RESULTS: _____mm SENT FOR CXR: _____

>10MM IS POSITIVE FOR ALL HEALTHCARE WORKERS

Brazos County Health Dept PKT Complete _____
Employee Injury Report Completed _____
Entered into shared drive spreadsheet _____

Consent for Treatment

I understand that I am seeking employee health services at/from a St. Joseph Health System Facility (the "Clinic") and give my voluntary consent to the attending practitioner or his/her designee(s), including other practitioners, facility personnel, and students, to perform and/or administer all screenings, examinations, diagnostic testing (laboratory, radiology, pulmonary function, FIT testing), immunizations, and treatment, which have been requested by _____, my prospective or current Employer.

I understand that Texas law provides that if any healthcare worker is exposed to my blood or other bodily fluid, my blood or other bodily fluid will be tested by this facility to determine the presence of any communicable disease, including but not limited to Hepatitis, Human Immunodeficiency Virus(which is the causative agent of AIDS), and Syphilis. I understand such testing is necessary to protect those who will be caring from me while I am receiving medical services at this facility. I understand that the results of the tests taken under these circumstances do not become part of my medical record.

☐ PATIENT'S RIGHTS AND RESPONSIBILITIES: I acknowledge receipt of the statement "Patients' Rights."

☐ NOTICE OF PRIVACY PRACTICES: I acknowledge receipt of the St. Joseph *Notice of Privacy Practices*.

This form has been fully explained to me and I certify that I understand its contents.

_____ _____

Signature of Patient (or Patient Representative) Date

_____

Printed Name of Patient (or Patient Representative)

_____

Authority of Representative to Act for Patient
(Relationship to Patient)

Patient Authorization for Release of Health Records – Testing or Treatment at Request of Employer

1. I authorize St. Joseph Health System to disclose information from the health records of:

Patient Name: _____ Date of Birth: _____

2. The information is to be disclosed to Patient's prospective or current employer as identified below ("Employer"):

Name of Employer: International Ocean Discovery Program

Address: 1000 Discovery Drive, College Station, TX 77845

Contact Person: Christina Peery

I authorize this information to be disclosed in the following ways (initial below):

_____ **Written/Photocopy/Paper**
_____ **Verbal**
_____ **Fax** at the following fax number: _____
_____ **Electronic Mail** at the following email address: _____

3. **Date(s) of Treatment:** _____

4. I authorize St. Joseph to disclose to Employer the results of all screenings, examinations, diagnostic testing (laboratory, radiology, pulmonary function, FIT testing), immunizations, and treatment provided to Patient at the request of Employer.

5. I understand that I may withdraw or revoke this authorization at any time. However, any disclosures already made pursuant to this authorization are unable to be taken back. I may revoke this authorization by notifying St. Joseph Health System in writing.

6. My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by Employer and may no longer be protected by Federal or Texas privacy regulations.

7. Unless revoked earlier, this authorization expires in one year unless I specify another time: _____.

8. I release St. Joseph Health System, its affiliates, and their employees and agents from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

_____ _____
Signature of Patient (or Patient Representative) Date

_____ _____
Printed Name of Patient (or Patient Representative) Authority of Representative to Act for Patient (Relationship to Patient)

01/12