



7501 West 15th Ave.
Gary, IN 46406
Phone #: (219) 977-2090
Fax #: (219) 977-2091

Audiometric Case History Information

Name: _____

Hire Date: _____

Job Title: _____

Birth Date: _____

Date of Last Hearing Exam: _____

S.S.#: _____

Reason: _____

Sex: M F

Circle all that apply (in the past year):

Ear pain	Right	Left	Both
Drainage from ear	Right	Left	Both
Dizziness	Right	Left	Both
ringing in the ear	Right	Left	Both
Plugged feeling in the ear	Right	Left	Both
Cold	Right	Left	Both
Hearing Difficulty	Right	Left	Both
Firearms/Guns	Right	Left	Both
Loud Music	Right	Left	Both

Place Test Results Here

I acknowledge that this information is accurate to the best of my knowledge and authorize the release of the above information and hearing test results to my employer, Comprehensive Care, and Mobilear Incorporated.

Sign: _____

Date: _____