WORK SAFE BC
WORKING TO MAKE A DIFFERENCE
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HEARING LOSS AND EMPLOYMENT QUESTIONNAIRE

Please answer all questions and complete this questionnaire in ink, and sign on the last page.

Worker's last name *(please print)* ❒ Mr. ❒ Ms. ❒ Mrs. ❒ Miss		First name(s)	Claim number
Mailing address		City	Postal code
Telephone number	Social insurance number	Personal health number from your BC CareCard	Date of birth

History

What problems do you notice with your hearing?

Have you consulted a physician or audiologist regarding your hearing loss? ❒ Yes ❒ No
If yes, please indicate name and date of appointment(s)

Approximately when were you first aware of problems with your hearing?
yyyy-mm-dd

Was this problem with your hearing ❒ Sudden? or ❒ Gradual?

Do you have ringing or other noises in your ears? ❒ Yes ❒ No ❒ Right ear ❒ Left ear

If yes, when did you first notice it?
yyyy-mm-dd

Comments

List all medications (prescribed or over-the-counter, including herbal remedies) currently taken

Name	**Why are you taking it?**

Do your parents, children, brothers, or sisters have hearing loss? ❒ Yes ❒ No If yes, please specify who	From what age?
Has any member of your family had ear surgery? ❒ Yes ❒ No If yes, please specify who	At what age?

History continued

Claim number

Please check (❐) appropriate boxes.

Have you ever had any of the following?				When?
Hearing aid	❐ Right ear	❐ Left ear	❐ No	
Ear infection	❐ Right ear	❐ Left ear	❐ No	
Ear pain	❐ Right ear	❐ Left ear	❐ No	
Ear surgery	❐ Right ear	❐ Left ear	❐ No	
Feeling of fullness in your ears	❐ Right ear	❐ Left ear	❐ No	

	Yes	No	When?
Sudden hearing loss	❐	❐	
Serious head injury	❐	❐	
Thyroid problems	❐	❐	
Whiplash	❐	❐	
High blood pressure	❐	❐	
Sudden intense noise (e.g. explosion)	❐	❐	
Diabetes	❐	❐	
Heart disease/attack	❐	❐	
Stroke	❐	❐	
Kidney problems or disease	❐	❐	
Dizziness/balance problems	❐	❐	
Antibiotics by intravenous (IV)	❐	❐	
Serious illness (e.g. cancer, tuberculosis, malaria, meningitis) — If yes, what was it and when did you have it?	❐	❐	

Comments

Firearm Noise History

	Yes	No
Have you **ever** been exposed to any firearms **outside of your work**?	❐	❐
If yes, was it for:		
Hunting	❐	❐
Firing range	❐	❐
Target/Trap/Skeet shooting	❐	❐

Check all types of firearms used:				Right	Left
❐ Rifle	Number of years		Shoulder shot from	❐	❐
❐ Shotgun	Number of years		Shoulder shot from	❐	❐
❐ Handgun	Number of years				

Claim number

Recreational Noise History

Have you ever used any of the following **outside of your work**?		Yes	No
Power tools	Number of years _____	❒	❒
Outboard boat engine	Number of years _____	❒	❒
Chain saw	Number of years _____	❒	❒
Small/prop airplane	Number of years _____	❒	❒
Motorcycle	Number of years _____	❒	❒
Car racing	Number of years _____	❒	❒
Amplified music	Number of years _____	❒	❒
Farm machinery	Number of years _____	❒	❒
Heavy equipment	Number of years _____	❒	❒

Employment Record

1. Age you left school	2. Date you retired *(if applicable)* *yyyy-mm-dd*	3. Date you last worked in noise *yyyy-mm-dd*
4. Were you in the military service? ❒ Yes ❒ No	If yes, during what period *From*	*To*
What was your job in the service?		
Were you exposed to loud noise or gunfire beyond basic training? ❒ Yes ❒ No		

5. Are you or have you been **dispatched** through a **union**? ❒ Yes ❒ No If no, skip to #6.
Name of union and your occupation
Length of time you worked through the union *From* *To*
List any jobs you were dispatched to **outside** of BC *(include locations and time periods for each)*

6. **SELF EMPLOYMENT**	WorkSafeBC account number(s)	Date(s) *yyyy-mm-dd*
Type of business(es) and occupation(s)		
Company name(s) and location(s)		
Personal Optional Protection ❒ Yes ❒ No		

Please continue on next page.

If all your work has been through union dispatch, please do not answer this area.

Claim number

7. List all the places you have worked starting from the time you left school until your current or most recent employer.

Employer's Name	Location (province and country if not in Canada)	Employment Period From MM/YY	To MM/YY	Type of Work (list all jobs for each employer and duration of each job)	Noise Sources and Exposure to Noise (hours/day)	Hearing Protection Yes	No

8. List all time periods you were not working *(do not include vacation)*

Signature	Date yyyy-mm-dd

Thank you for completing this questionnaire and please attach extra forms if required.