

**Workers' Compensation Division
Employee and Physician's Report of
Occupational Hearing Loss**

**Worker's Compensation Division
Occupational Hearing Loss Unit
Post Office Box 791
Charleston, WV 25322-0593**

WC-1HL-A

Name: _____ SS#: _____ Claim#: _____ DOI: _____

NON-OCCUPATIONAL NOISE EXPOSURE HISTORY

Protections Used ?

	YES	NO	HOW OFTEN	YES	NO	TYPE (Plugs , Muffs or Caps)
Hunting	[]	[]	_____	[]	[]	_____
Trap Shooting	[]	[]	_____	[]	[]	_____
Firing Range	[]	[]	_____	[]	[]	_____
Loud Music	[]	[]	_____	[]	[]	_____
Walkman	[]	[]	_____	[]	[]	_____
Weed Eater	[]	[]	_____	[]	[]	_____
Lawn Mower	[]	[]	_____	[]	[]	_____
Power Tools	[]	[]	_____	[]	[]	_____
Chain Saw	[]	[]	_____	[]	[]	_____
Skill Saw	[]	[]	_____	[]	[]	_____
Band Saw	[]	[]	_____	[]	[]	_____
Air Compressor	[]	[]	_____	[]	[]	_____
Heavy Equipment	[]	[]	_____	[]	[]	_____
Farm Machinery	[]	[]	_____	[]	[]	_____
Auto Mechanic	[]	[]	_____	[]	[]	_____
Racing	[]	[]	_____	[]	[]	_____
Pilot	[]	[]	_____	[]	[]	_____
Motorcycle	[]	[]	_____	[]	[]	_____
Snow Mobile	[]	[]	_____	[]	[]	_____
Indoor Athletics	[]	[]	_____	[]	[]	_____
Other : _____	[]	[]	_____	[]	[]	_____
Other : _____	[]	[]	_____	[]	[]	_____

MILITARY SERVICE :

Do you have prior military service ? Yes [] No [] If yes , which branch : _____
 Did you have a combat assignment ? Yes [] No [] If yes , how long : _____
 What was your job in the military : _____ How many weeks of basic training : _____
 Noise exposure other than basic training : _____

Military Address/Location	Service From - To	Job Description	Type of Machinery/Equipment Used	Exposure to Noise HRS./Days	Hearing Protection Worn ?

Comments: _____

Compensation History and Physical

Name : _____ Date: _____ SSN: _____ CLAIM #: _____ DOI: _____
 Referred by: Worker's Compensation

A. 1. HISTORY OF HEARING LOSS

- Hearing loss began when (approximately) : 12 years ago.
- Hearing loss : Both Ears (right/left) Equal More Right More Left
- Do you have trouble hearing any of the following :
 - Telephone Spouse In Crowd
 - Room Next Door Music Door Bell
- Tinnitus (Ringing in the ears) Yes No
 - If Yes Both ears Right ear Left ear

2. EMPLOYMENT HISTORY

(List all employment beginning with most recent. Attach a separate page if necessary.):				
Employer's Name & Address	From	To	Description of Duties	Hearing Protection (Yes or No)

3. GENERAL MEDICAL HISTORY

- | | | | | | |
|---|------------------------------|-----------------------------|------------------------------|------------------------------|-----------------------------|
| Heart Trouble | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mumps & Measles | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Scarlet Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Meningitis | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Smoking | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Head Injury | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Kidney Problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ear Surgery | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High Fever | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | | |
| Any hearing loss resulting from these conditions? | | | <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| If Yes , Explain : _____ | | | | | |

4. CONDITIONS CONTRIBUTING TO THE HEARING LOSS

- Drugs that may have caused hearing loss Yes No
 If Yes , Explain : _____
- Chemicals Exposure Yes No
 If Yes , Explain : _____