



HEARING LOSS AND EMPLOYMENT QUESTIONNAIRE

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

CLAIMS CALL CENTRE

Phone 604 231-8888
Toll-free 1 888 967-5377
M-F, 8:00 a.m. to 4:30 p.m.

FAX

604 233-9777
Toll-free 1 888 922-8807

MAIL

WorkSafeBC
PO Box 4700 Stn Terminal
Vancouver BC V6B 1J1

Worker information

| | | | | |
|------------------------------------|--|--------------------------------------|-------------------------|-------------------------------------------------------------------------|
| | | Customer care number | WorkSafeBC claim number | |
| Worker last name | | First name | | Middle initial |
| Address line 1 | | Preferred first name | | |
| Address line 2 | | City | Postal code/zip | Province/state |
| Phone number (include area code) | | Country (if not Canada) | | Worker's occupation |
| Business phone (include area code) | | Business ext. | E-mail address | |
| | | | | Gender Male <input type="checkbox"/> Female <input type="checkbox"/> |
| Date of birth (yyyy-mm-dd) | | Personal health number (BC CareCard) | | Social insurance number |

Employer information

| | | | | |
|----------------------------|------------------|----------------------------------|---------------------------------------------|-------------------------|
| Employer organization name | | Phone number (include area code) | | |
| Mailing address 1 | | City | | Postal code/zip |
| Mailing address 2 | | Province/state | | Country (if not Canada) |
| Operating location code | Type of business | | Employer's phone number (include area code) | |

History

| | | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------|--|------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|----------------------------------------------------|
| What problems do you notice with your hearing? | | | | |
| Approximately when were you first aware of problems with your hearing? (yyyy-mm-dd) | | | | |
| Have you consulted a physician or audiologist regarding your hearing loss? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | If yes, indicate name and date of appointment(s) | |
| Is your hearing better in one ear than the other? Please explain. Right ear <input type="checkbox"/> Left ear <input type="checkbox"/> | | | What happened? Was this problem with your hearing <i>Sudden</i> or <i>Gradual</i> ? Please explain. | |
| Do you have ringing or other noises in your ears? Yes <input type="checkbox"/> No <input type="checkbox"/> | | Which ear? Right ear <input type="checkbox"/> Left ear <input type="checkbox"/> | | If yes, when did you first notice it? (yyyy-mm-dd) |
| 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 <input type="checkbox"/> No <input type="checkbox"/> | | | If yes, specify who | |
| | | | From what age? | |
| Has any member of your family had ear surgery? Yes <input type="checkbox"/> No <input type="checkbox"/> | | | If yes, specify who | |
| | | | At what age? | |





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| | | | |
|------------------|------------|-------------------------|-----------------------------------------|
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History continued

| Have you ever had any of the following? | | | | When? |
|------------------------------------------------------------------------------------------------------------------|------------------------------------|-----------------------------------|-----------------------------|-------|
| Hearing aid | Right ear <input type="checkbox"/> | Left ear <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Ear infection | Right ear <input type="checkbox"/> | Left ear <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Ear pain | Right ear <input type="checkbox"/> | Left ear <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Ear surgery | Right ear <input type="checkbox"/> | Left ear <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Feeling of fullness in your ears | Right ear <input type="checkbox"/> | Left ear <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| | | | | When? |
| Sudden hearing loss | | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Serious head injury | | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Thyroid problems | | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Whiplash | | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| High blood pressure | | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Sudden intense noise (e.g. explosion) | | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Diabetes | | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Heart disease/attack | | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Stroke | | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Kidney problems or disease | | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Dizziness/balance problems | | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Antibiotics by intravenous (IV) | | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Serious illness (e.g. cancer, tuberculosis, malaria, meningitis) – If yes, what was it and when did you have it? | | Yes <input type="checkbox"/> | No <input type="checkbox"/> | _____ |
| Comments | | | | |
| _____ | | | | |
| _____ | | | | |

Firearm noise history

| | | | |
|---------------------------------------------------------------------------------|-----------------------|------------------------------|--------------------------------------------------------------|
| Have you ever been exposed to any firearms outside of your work ? | | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| If yes, was it for: | | | |
| Hunting | | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Firing range | | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Target/trap/skeet shooting | | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| Check all types of firearms used: | | | |
| <input type="checkbox"/> Rifle | Number of years _____ | Shoulder shot from | Right <input type="checkbox"/> Left <input type="checkbox"/> |
| <input type="checkbox"/> Shotgun | Number of years _____ | Shoulder shot from | Right <input type="checkbox"/> Left <input type="checkbox"/> |
| <input type="checkbox"/> Handgun | Number of years _____ | | |



| | | | |
|-------------------------|------------|-----------------------------------------|-------------------------|
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Recreational noise history

| Have you ever used any of the following outside of your work ? | Number of years |
|-----------------------------------------------------------------------|-----------------|
| <input type="checkbox"/> Power tools | _____ |
| <input type="checkbox"/> Outboard boat engine | _____ |
| <input type="checkbox"/> Chain saw | _____ |
| <input type="checkbox"/> Small/prop airplane | _____ |
| <input type="checkbox"/> Motorcycle | _____ |
| <input type="checkbox"/> Car racing | _____ |
| <input type="checkbox"/> Amplified music | _____ |
| <input type="checkbox"/> Heavy equipment | _____ |

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 <input type="checkbox"/> No <input type="checkbox"/> | | If yes, during what period? (yyyy-mm-dd) from _____ to _____ |
| What was your job in the service? | | |
| Were you exposed to loud noise or gunfire beyond basic training? | | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 5. Are you or have you been dispatched through a union ? | | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Name of union | 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) | | |

Self employment

| | | |
|------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|
| 6. Do you deduct business or equipment expenses from your employment income? Yes <input type="checkbox"/> No <input type="checkbox"/> | If yes, what is your type of employment? Hired on a contract basis <input type="checkbox"/> Partner or principal <input type="checkbox"/> Fisher <input type="checkbox"/> | |
| 7. Company name(s) and locations(s) | | |
| 8. Do you have an account with WorkSafeBC (POP – personal optional protection)? Yes <input type="checkbox"/> No <input type="checkbox"/> | If yes, what are your account number(s)? | Date(s) (yyyy-mm-dd) |

The Workers' Advisers Office is independent and separate from WorkSafeBC and provides free advice and assistance to help injured workers with their claims. They have offices throughout the province and can be contacted at www.labour.gov.bc.ca/wab/ or by telephone: Richmond 604 713-0360, toll-free 1 800 663-4261; Victoria 250 952-4393, toll-free 1 800 661-4066; Kelowna 250 717-2096, toll-free 1 866 881-1188.

Please complete the employment history record sheet on page 4.

