



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 (please include area code)		Country (if not Canada)		Worker's occupation
Business phone (please 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 (please 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 (please 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, please 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, please specify who	
			From what age?	
Has any member of your family had ear surgery? Yes <input type="checkbox"/> No <input type="checkbox"/>			If yes, please specify who	
			At what age?	





HEARING LOSS AND EMPLOYMENT QUESTIONNAIRE

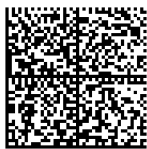
Worker last name	First name	Middle initial	WorkSafeBC claim number
		Social insurance number	Personal health number from BC CareCard

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 _____		



Worker last name	First name	Middle initial	WorkSafeBC claim number
Social insurance number		Personal health number from BC CareCard	

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?	If yes, what is your type of employment?		
Yes <input type="checkbox"/> No <input type="checkbox"/>	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.

