VERNICK & GOPAL
HEARING CENTER
1244 BOYLSTON ST. SUITE 303
CHESTNUT HILL, MA 02467
Office # 617-383-6830 Fax # 617-383-6880

PATIENT UPDATE FORM

Date: _____

Name: _____ DOB: _____ SSIMED #: _____ (office use)

Reason for visit/ Chief complaint: _____

Primary care physician: _____

Referring physician: _____

How did you hear about us? _____

Do you have difficulty hearing? Yes No If so, how long? _____

Is one ear poorer than the other? Yes No If so, which one? _____

Is this a sudden loss or has it gotten worse slowly over time? Suddenly Slowly

Do you hear noises in your ear(s) such as ringing, buzzing, etc.? Yes No

If so, in what ear(s)? Right Left Both

Do you experience dizziness? Yes No Is the dizziness: Constant Daily Occasional

Has your dizziness ever been evaluated or treated? Yes No explain: _____

Have you been consistently around excessively loud noises? Yes No

If so, what type of noise? Auto Construction Military Aircraft Firearms Music Other: _____

How long were you exposed to this noise? _____

Do you have a history of ear infections? Yes No If so, please describe _____

Do you have a history of ear surgery? Yes No If so, please describe _____

Do you currently wear hearing aids? Yes No If so, what ears? Right Left Both

Do you have any family history of hearing loss? Yes No If so, who? _____

Do you have any history of head injury? Yes No If so, please explain _____

Do you suffer from hypertension (high-blood pressure)? Yes No

Please list current medical conditions/ diagnoses: _____

_____

_____

Please list past hospitalizations or surgeries: _____

_____

_____