AUDIOLOGY SERVICES
VERNICK & GOPAL, LLC

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617-383-6830

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)?

Please list current medical conditions/ diagnoses: ______________________________

____

Please list current medications: ____

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Please list past hospitalizations or surgeries: __________________________________

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