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

Demographics:

Patient's Last Name: _____ First Name: _____

Social Security # (SSN): _____-_____-_____ Male ☐ Female ☐

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Business Phone: _____

Mobile/Other: Phone: _____ Birthdate: _____/_____/_____

Marital Status: ☐ Married ☐ Divorced ☐ Single **Email:** _____

Health Status: ☐ Hearing Impaired ☐ Visually Impaired ☐ Disabled

Emergency Contact/Nearest Relative Information:

Name: _____

Relationship: Spouse ☐ Brother ☐ Sister ☐ Daughter ☐ Son ☐ Parent ☐ Friend ☐ Other ☐ _____

Telephone or Cell Phone (best way to reach): _____

Referral Information:

Primary Care Physician:

Name: _____

Address: _____

Telephone #: _____

Fax #: _____

Referring Physician:

Name: _____

Address: _____

Telephone #: _____

Fax #: _____

Insurance Information:

Primary Insurance: _____ Membership ID: _____

Group #: _____ Carrier's Name: _____

Carrier's DOB: _____ Relationship to Patient: _____

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Secondary Insurance: _____ Membership ID: _____

Group #: _____ Carrier's Name: _____

Carrier's DOB: _____ Relationship to Patient: _____

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NEW PATIENT REGISTRATION FORM

Name:_____DOB:_____

Primary Care Physician:_____Occupation:_____

I. Primary Symptom (s):_____

_____

II. Present Symptoms and Hearing Complaints:

Hearing Loss: Both Ears Right Only Left Only N/A

When did your hearing loss first begin?_____

Do you know what caused your hearing loss?_____

Has your hearing changed? (i.e. sudden, gradual, fluctuating)_____

Do you have a better hearing ear?_____

Tinnitus (Noise in ears): Both Ears Right Only Left Only N/A

Describe the sound:_____

When did it first occur?_____

Is the sound constant or periodic?_____

If periodic, how often does it occur?_____

Is the sound distressing to you? If yes, describe:_____

Feeling of Fullness: Both Ears Right Only Left Only N/A

When did the fullness first occur?_____

Constant or periodic?_____

If periodic, how often does it occur?_____

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Dizziness/Unsteadiness: _____ None

Describe the symptom(s):_____

When did it first occur?_____

Constant or periodic?_____

If periodic, how long does it last?_____

Noise History:

Do you have military experience?

YES NO

Have you been exposed to noise in the past 14 hours?

YES NO

If yes, did you wear hearing protection during the entire noise exposure?

YES NO

When in high noise areas, I use hearing protection: 0% 20% 40% 60% 80% 100%

Type of hearing protection used _____

Have you ever participated in any of the following? Circle all that apply.

Chain saw	Dirt bike or loud RV	Firearms	Loud Music
Lawn Equipment	Wood working equipment	Other Noise Exposure_____	

Hearing Aids: Both Ears Right Only Left Only N/A

Make:_____

Model:_____

Style:_____

Year:_____

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Ear Infections/Middle Ear Problems: Both Ears Right Only Left Only N/A

Describe condition(s):_____

Previous treatment(s):_____

III. **In the past 90 days have you experienced:**

Ear Pain:	Both Ears	Right Only	Left Only	N/A
Ear Discharge:	Both Ears	Right Only	Left Only	N/A
Sudden Change in Hearing:	Both Ears	Right Only	Left Only	N/A

IV. **Have you seen a physician or ear specialist in the last six months?**

YES NO

Doctor's Names:_____

_____

V. **Have you ever had any of the following physical conditions? Circle Yes or No and describe.**

Middle Ear Infections_____	YES	NO
Ear Surgery_____	YES	NO
Ear Malformations_____	YES	NO
Vision Loss_____	YES	NO
Cleft Palate_____	YES	NO
Heart Defect_____	YES	NO
Kidney disease or infection_____	YES	NO

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Arthritis_____	YES	NO
Diabetes_____	YES	NO
Bones that break easily_____	YES	NO
Learning Impairment_____	YES	NO
High blood pressure_____	YES	NO
Head injury/unconsciousness_____	YES	NO
Mumps_____	YES	NO
Scarlet Fever_____	YES	NO
Measles_____	YES	NO
Meningitis_____	YES	NO
Allergies_____	YES	NO
Chemo/Radiation_____	YES	NO

VI. **Family History of Hearing Loss:**_____

_____

_____

VII. **Please list all medications you are currently taking and allergies: (See attached Medication Form)**

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Medication Form

Patient's Name: _____

D.O.B. _____

Date of Service: _____

Drug / Medication Information

List all medications you are currently taking: Include prescription drugs, inhalers, aspirin products, non-steroidal anti-inflammatories, eye drops, herbal supplements, nutritional supplements, vitamins, over-the-counter medications and non-prescription drugs.

Medication/Drug Name	Dose	Frequency	When You Last Took Medication

Please list any known allergies:

_____

_____

_____

Instructions: Please check "yes," "no," or "sometimes" in response to each of the following items. Do not skip a question if you avoid a situation because of a hearing problem. If you use a hearing aid, please answer the way you hear without the aid.

	Item	Yes (4 pts)	Sometimes (2 pts)	No (0 pts)
E	Does a hearing problem cause you to feel embarrassed when meeting new people?			
E	Does a hearing problem cause you to feel frustrated when talking to members of your family?			
S	Do you have difficulty hearing when someone speaks in a whisper?			
E	Do you feel handicapped by a hearing problem?			
S	Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?			
S	Does a hearing problem cause you to attend religious services less often than you would like?			
E	Does a hearing problem cause you to have arguments with family members?			
S	Does a hearing problem cause you difficulty when listening to TV or radio?			
E	Do you feel that any difficulty with your hearing limits or hampers your personal or social life?			
S	Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?			
	TOTAL SCORE = _____ (sum of the points assigned to each of the items)			