VERNICK&GOPAL, LLC
1244 Boylston Street • Suite 303 • Chestnut Hill, MA 02467
Phone: 617-383-6830
Fax: 617-383-6880

Hearing Questionnaire

Name: _____ Date: _____ Patient # _____
Office Use

Primary Care Physician: _____ Referring Physician: _____

How did you hear about our practice? _____

Reason for today's visit: _____

Do you have difficulty hearing? Yes No
Is the loss gradual or sudden? _____

Is one ear poorer than the other? Yes No
Which ear is poorer? _____

Do you hear noises in your ears like ringing or buzzing? Yes No
Do you hear it in one or both ears? _____

Do you experience dizziness? Yes No
Has this been evaluated or treated? Yes No

Are you **or** have you been around loud noise consistently? Yes No
Do or did you wear hearing protection? Yes No

Do you have a history of ear infections? Yes No

Do you have a history of ear surgery? Yes No
What type of surgery? When? _____

Do you wear hearing aids? Yes No

Do you have a history of head injury? Yes No

Do you have any family history of hearing loss? Yes No

Which members? _____

Please list your current or prior medical conditions:

Please list any hospitalizations or surgeries: