Elena L. Maresca Au.D.
Hearing and Tinnitus Management
207 Hallock Road, Suite 208
Stony Brook, NY 11790
(631) 780-HEAR
www.liaudiology.com

PATIENT INFORMATION

DATE _____

NAME Dr. Mr. Mrs. Ms. Miss. _____

ADDRESS _____

_____

DATE OF BIRTH _____

OCCUPATION _____

HOME PHONE # _____

CELL PHONE # _____

MAY WE LEAVE A MESSAGE? _____

SECONDARY CONTACT _____

RELATIONSHIP TO PATIENT _____

MAY WE DISCUSS CASE WITH SECONDARY CONTACT? _____

PRIMARY CARE PHYSICIAN _____

EAR NOSE & THROAT PHYSICIAN _____

REFERRING PHYSICIAN _____

HOW DID YOU HEAR OF OUR PRACTICE_____

_____

_____

_____

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CASE HISTORY

Name _____ Date _____
Address _____
_____
Telephone Number _____
Date Of Birth _____

GENERAL INFORMATION

Primary Care Physician _____
Referring Physician _____
Have you been to this office before?
NO YES How long ago? _____
Who referred you for this evaluation?
___ Self
___ Spouse / Family member
___ Friend
___ Doctor Doctor Name _____
___ Nurse/LPN Name _____
___ Other _____
For what reason was this appointment scheduled?
___ To evaluate hearing
___ Ringing in the ear(s)
___ Dizziness/Loss of balance
___ Ear Infection(s)
___ Other_____

HISTORY

Check the following that may apply:
___ History of ear "problems"
___ History of ear surgery
___ History of dizziness or loss of balance
___ History of occupational or recreational noise exposure (military, hunting, construction, factory etc.)
___ History of allergy or sinus problems
___ Family history of hearing loss
___ Family history of dizziness or loss of balance
___ Family history of illness

___ Other medical conditions _____

MEDICATIONS

Please list all medications you are currently taking:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

HEARING LOSS

Do you have a known hearing loss?

NO YES

Is one ear better than the other?

RIGHT LEFT BOTH EARS ARE THE SAME

How long have you noticed the hearing loss

_____DAYS _____WEEKS _____MONTHS _____YEARS

Has the hearing loss occurred gradually over time or suddenly?

GRADUALLY SUDDENLY

Do you know the cause of your hearing loss?

NO YES *Please list:*_____

Do you have any history of noise exposure such as military service, construction, machinery, dentistry, police, fireman, hunting, musician, etc?

NO YES *Please list*:_____

RINGING IN THE EAR(S)/TINNITUS

Do you have ringing in your ear(s)?

NO YES

If yes how long has the ringing been present?

_____DAYS _____WEEKS _____MONTHS _____YEARS

In which ear(s) is the ringing present?

BOTH RIGHT LEFT

Is the ringing constant or does it occur in episodes?

CONSTANT EPISODIC

Is the ringing a high pitch (bird chirp) or a low pitch (deep like a fog horn)

HIGH PITCH LOW PITCH

Is the ringing pulsing or steady?

PULSING STEADY

DIZZINESS/LOSS OF BALANCE

Do you have a history of dizziness or balance problems?

NO YES

The dizziness or loss of balance is:

___ Constant
___ Episodic, “comes and goes”
___ Only upon movement
___ Accompanied by nausea

___ Other information _____

HEARING AID(S)

I am currently using a hearing aid(s)

NO YES

Hearing Aid information

Date of Purchase _____

Fitting Facility _____

Right ear NONE IN THE EAR BEHIND THE EAR

Left ear NONE IN THE EAR BEHIND THE EAR

I feel my hearing aid(s) help me

NO YES

If no please explain _____

COMMUNICATION

Do you have problems in the following situation?

___ Normal conversations
___ Group situations
___ Background noise
___ At work
___ Television
___ Telephone
___ Other _____

How does you hearing loss affect others? (Family & Friends)

_____

_____

Is there someone who is more concerned about your hearing than you are?

_____

Does difficulty with your hearing restrict your social or personal life?

_____

I am interested in a new hearing aid(s)

NO YES

I am interested in a hearing aid(s) repair

NO YES

OTHER INFORMATION YOU WOULD LIKE TO SHARE

_____

_____

_____

_____

_____

PLEASE BRING THIS FINISHED FORM TO YOUR AUDIOLOGY APPOINTMENT

THANK YOU