

Heard It Through The Grapevine Audiology, PC

Do you currently use tobacco products? Yes No

Please check any of the following that you currently have or have had in the past:

Arthritis	Heart Trouble	Measles	Parkinson's	Cancer
Asthma	Hepatitis	Meningitis	Scarlet fever	Mumps
Bell's Palsy	Sinusitis	Diabetes	HIV	Malaria
Alzheimer's/ Dementia	Stroke/TIA	Head injury	Sickle Cell	Zika virus
Skin sensitivities	Vision loss	High blood pressure		
Need for regular MRI testing		COVID-19		
Compromised immune system		Implantable medical device		
Bleeding disorder		Thyroid disorder		
Other:	_____			

Please list the month and year you either received a COVID-19 vaccine or were diagnosed with COVID-19. _____

Do you have any of the following?:

Deformity of the ear	Yes	No	
Sudden or rapid hearing loss in the past 90 days	Yes	No	
Has the hearing in one ear worsened in the past 90 days?	Yes	No	
Do you ever have ear pain?	Yes	No	
In which ear is your hearing the worst?	Left	Right	Same
Have you ever found it necessary to have a doctor remove wax from your ears?	Yes	No	

Hearing History

Chief concern:

Hearing Loss (Right ear/ Left ear)	Tinnitus/Ringing	Dizziness
Difficulty hearing (in Quiet in Noise)	Telephone (Right ear Left ear)	

How long have you noticed this difficulty? _____

Is this problem due to a work-related injury/exposure? Yes No

If so: Date of Injury: _____ Explain: _____

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Do you feel your hearing is changing? Yes No(Gradual Sudden)

Have you ever had radiation to your head or neck? Yes No

Did you ever have concerns regarding academic performance and/or diagnosed learning difference?

Have you ever been exposed to loud noise, either recently or in the past? Yes No

If so, please mark all that apply:

Farm Machinery

Music

Hunting/Shooting

Factory Noise

Power Tools

Military

Jet Engines

Other: _____

Have you had your hearing tested before? Yes No

If so, who did you see? _____ When? _____

Is there a history of hearing loss in your family? Yes No

If so, who? _____

Do you have a hearing aid? Yes No

How many years have you worn a hearing aid? _____

What would improve your current hearing aid? _____
