Heard It Through The Grapevine Audiology, PC

Patient First Name: _____ **Patient Last Name:** _____
Date of Birth: _____ **Age:**_____ **Date:**_____

Annual Medical History

Do you feel your hearing has changed since your previous evaluation? ☐Yes ☐No
If yes, please describe:

_____

_____

Have you seen an Ear, Nose and Throat Physician since your last evaluation? ☐Yes ☐No
If so, who did you see? _____

Please indicate any CHANGES to medical history since your last evaluation (i.e. new diagnoses):

☐Arthritis	☐Asthma	☐Bell's Palsy	☐Neurological Symptoms
☐Heart Trouble	☐Hepatitis	☐Sinusitis	☐Stroke/TIA
☐Measles	☐Meningitis	☐Diabetes	☐Head Injury
☐Parkinson's	☐Scarlet Fever	☐HIV	☐Sickle Cell
☐Cancer	☐Mumps	☐Malaria	☐Zika Virus
☐COVID-19	☐Vision Loss	☐High Blood Pressure	
☐Other:			

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

_____

Do you take any prescription medications on a regular basis? Please list:

Medication:_____For:_____Dosage:_____
Medication:_____For:_____Dosage:_____
Medication:_____For:_____Dosage:_____
Medication:_____For:_____Dosage:_____
Medication:_____For:_____Dosage:_____
Medication:_____For:_____Dosage:_____
Medication:_____For:_____Dosage:_____
Medication:_____For:_____Dosage:_____
Medication:_____For:_____Dosage:_____
Medication:_____For:_____Dosage:_____

Do you currently use tobacco products? ☐Yes ☐No

HEARING AID USER:

Do you have any concerns or issues regarding your current hearing aid? ☐Yes ☐No

If yes, please describe:

_____

_____