# 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:____________________
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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:

______________________________________________________________________________

______________________________________________________________________________