Heard It Through The Grapevine Audiology, PC

Patient Name:______________________________ **Age:**__________ **Date:**________________

Medical History

Have you seen an Ear, Nose and Throat Physician? ☐ Yes ☐No
If so, who did you see?___________________________ When? _______________________

Have you seen any other type of doctor in the last 3 months? ____________________

Have you ever had surgery that may have affected your hearing or surgery on your ear? ☐ Yes ☐No

Have you ever had an ear infection? ☐ Yes ☐No (If yes, ☐as a ch

Have you, in the past 10 years, experienced chronic or acute dizziness, lightheadedness, or vertigo?

☐ Yes ☐No If yes, please describe:____

During the past month, have you often been bothered by feeling down, depressed, or hopeless?
☐Not at all ☐Several days ☐More than half the days ☐Nearly everyday

During the past month, have you often been bothered by little interest or pleasure in doing things?
☐Not at all ☐Several days ☐More than half the days ☐Nearly everyday

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

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
☐ Neurological Symptoms	☐ Stroke/TIA	☐ Head Injury	☐Sickle Cell	☐Zika Virus
	☐ Visual Trouble-Loss/Sight		☐ High Blood Pressure	

☐Other: ____

Heard It Through The Grapevine Audiology, PC

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:____

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

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?
If so, who did you see?___________________________ When? _______________________

Is there a history of hearing loss in your family? ☐ Yes ☐No If so, who?

Have you noticed that people seem to mumble?	Yes No
Do you find yourself asking people to repeat what they have said?	Yes No
Do you sometimes hear words but don't always understand them?	Yes No
Do you find it difficult to hear in noisy places?	Yes No
Have you been told that you speak loudly?	Yes No
Do you find it difficult to understand speech when your back is to the speaker?	Yes No
Do others complain that you set the TV too loud?	Yes No
Have you been told on occasion that you have missed the ringing of a telephone?	Yes No
Do you find it difficult to hear when using the telephone?	Yes No
Do you avoid social events because of your hearing difficulty?	Yes No
Do you have a hearing aid?	Yes No
	Right Left
How many years have you worn a hearing aid?	__________

What would improve your current hearing aid? ____

Please rank the following in order of importance (1-4), if a hearing aid is recommended for you:
____ Improved hearing in quiet ____ Improved hearing in noise
____ Cosmetic appearance ____ Expense

Heard It Through The Grapevine Audiology, PC

<u>HEARING AID USER:</u> ***(While wearing your hearing aid)***

I can hear but I have difficulty understanding	Yes	No
I have difficulty understanding when two or more are talking	Yes	No
I have difficulty understanding when in a crowd	Yes	No
I have difficulty understanding at a distance	Yes	No
I have difficulty knowing from which direction sounds are coming	Yes	No
I have difficulty while using the telephone	Yes	No
My own voice sounds hollow and unnatural	Yes	No
Words often run together	Yes	No
My hearing aid(s) don’t make the sounds loud enough	Yes	No
Some sounds are too loud	Yes	No
My hearing aid(s) make sounds tinny	Yes	No
My hearing aid(s) whistles	Yes	No
My hearing aid(s) makes my ear sore	Yes	No