Heard It Through The Grapevine Audiology, PC

Patient Name:_____ **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?_____
When? _____
For?_____

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

☐ 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: _____

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: _____
_____