Ear, Nose, and Throat Consultants, Inc.

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Adult Audio History

Patient's Name:____
Date: ___/___/____
DOB: ___/___/____
Referring Provider: _____________________________________

	YES	NO	
History of loud noise exposure:	O	O	______________
Tinnitus (Ringing Sound):	O	O	______________

Right Ear	Left Ear	Both
O	O	O

Pulsating	Intermittent	Constant
O	O	O

	YES	NO	
History of Ear Infection:	O	O	______________
Dizziness:	O	O	______________
Vertigo (Spinning):	O	O	______________
Do you wear a hearing aid:	O	O	______________
Feeling of ear fullness:	O	O	______________

Did you have any previous

	YES	NO	
CT scan of ears/head?	O	O	Date: ___________
MRI of ear/head?	O	O	Date: _______________

	YES	NO	
History of Ear Surgery:	O	O	____________________

Date:_______________
Type:_______________

Family history of hearing loss: O O ______________________
Mothers Side:____________
Fathers Side:____________

Family history of Dizziness: O O ___________________
Mothers Side: _______________
Fathers Side: ________________

OTHER:
____
____
____

Did you have any previous hearing tests done? O O Date:________________

Do you have any ear disorders? O O ____