Ear, Nose, & Throat Consultants, Inc.

Jeffrey S. Brown, M.D., F.A.C.S.
Thomas H. Costello, M.D.,F.A.C.S.
Andrew M. Doolittle, M.D.
K. Holly Gallivan M.D., M.P.H., F.A.C.S.
Brianna N. Crane, PA-C
Elizabeth A. McDonald, PA-C

Annemarie Czarnota,M.S., CCC-A
Alysia S. Moon, Au.D., CCC-A
Rachael E. Zugel, M.S., CCC-A
Hearing and Balance Center

1021 Main Street, Suite 105
Winchester, MA 01890
Tel: 781-729-8845
Fax: 781-729-6439

100 Trade Center, Suite 750
Woburn, MA 01801
Tel: 781-937-3001
Fax: 781-937-3070

Adult Audio History

Patient's Name: _____

Date: _____/_____/_____

DOB: _____/_____/_____

Referring Provider: _____

	YES	NO	
History of loud noise exposure:	☐	☐	_____
Tinnitus (Ringing Sound):	☐	☐	_____
Right Ear ☐ Left Ear ☐ Both ☐			
Pulsating ☐ Intermittent ☐ Constant ☐			
History of Ear Infection:	☐	☐	_____
Dizziness:	☐	☐	_____
Vertigo (Spinning):	☐	☐	_____
Do you wear a hearing aid:	☐	☐	_____
Feeling of ear fullness:	☐	☐	_____
Did you have any previous MRI scan of ears/head?	☐	☐	_____
Date: _____			
Did you have any previous CT scan of ears/head?	☐	☐	_____
Date: _____			
Did you have any previous hearing tests done?	☐	☐	_____
Date: _____			
Do you have any ear disorders?	☐	☐	_____

	YES	NO	
History of Ear Surgery:	☐	☐	_____
Date: _____			
Type: _____			
Family history of hearing loss:	☐	☐	_____
Mothers Side: _____			
Fathers Side: _____			
Family history of dizziness:	☐	☐	_____
Mothers Side: _____			
Fathers Side: _____			

OTHER:

_____

_____

_____

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