ADVANCED E·N·T Specialists

Name: _____ DOB: _____

Address: _____ AGE: _____

_____ DOE: _____

Referred By: _____ Audiologist: K. Johnson, Au.D., CCC-A

Please answer these questions to the best of your ability.

History:

Briefly describe your problem:

_____

_____

_____

_____

Describe your first episode:

Date of onset: _____

What were you doing when it began?

_____

What were the first symptoms?

_____

How long did these symptoms last? □ Seconds □ Minutes □ Hours □ Days □ Constant

On a scale of 1 to 10, how severe were they? _____

(1 being Not Severe and 10 being Extremely Severe)

Do you know what caused your problem? □ Yes □ No

If yes, what? _____

Have you had more than one episode of dizziness? □ Yes □ No

If yes, how often do these episodes occur? _____

Since the first one, are they becoming more frequent? □ Yes □ No

Since the first one, are they becoming less frequent? □ Yes □ No

How long do these symptoms last? _____

Describe a typical episode: _____

Have you experienced nausea or vomiting? □ Yes □ No

If yes, how often? _____

If yes, do you think it is related to your dizziness? _____

Does anything make your symptoms worse? □ Yes □ No

If yes, what? _____

Does anything make your symptoms better? □ Yes □ No

If yes, what? _____

Are you having any symptoms now? □ Yes □ No

If yes, what? _____

When was your last episode of dizziness? _____

Please answer the following questions:

Do loud noises cause your dizziness? □ Yes □ No

If you have an earache, are you also dizzy at that time? □ Yes □ No

Do you think your dizziness is related to your menstrual periods? □ Yes □ No □ N/A

Do you think your dizziness is related to changes in weather? □ Yes □ No

Do you think that stress make your dizziness worse? □ Yes □ No

Is your dizziness worse when you are tired? □ Yes □ No

The following information will help us understand your symptoms. Please check those items that describe your symptoms and circle words in parentheses as needed.

□ You are off balance. □ when dizzy □ when not dizzy
□ You are lightheaded. □ when dizzy □ when not dizzy
□ You have sensation of falling (right/left) (constantly/occasionally). □when dizzy □ when not dizzy

□ Changes in body position increase the dizziness

If yes, check those that apply:

□ Turning to the (right/left) while standing increases the dizziness
□ Bending over (forward/backward) increases the dizziness
□ (Sitting up/Standing up) increases the dizziness
□ Turning to the (right/left) while lying down increases the dizziness

□ Changes in head position increase the dizziness

If yes, then: □ Turning your head to the (right/left) increases the dizziness

□ Do you ever feel dizzy when you are (looking up/looking down)?
□ While walking on level surfaces do you veer to the (right/left)? □when dizzy □ when not dizzy

Please check all that apply:

□ Changing direction increases my dizziness.
□ Walking around corners increases my dizziness.
□ Walking in the dark increases my dizziness.
□ Walking up/down stairs increases my dizziness.
□ Riding in elevators increases my dizziness.
□ Riding up/down escalators increases my dizziness.
□ Walking in shopping malls increases my dizziness.
□ It bothers me to have people stand too close to me. □ when dizzy □ when not dizzy
□ Ladders and/or heights bother me. □ all my life □ new problem
□ Driving a car bothers me (in the daytime/at night) □ all my life □ new problem
□ Riding in a car bothers me (in the daytime/at night) □ all my life □ new problem
□ Riding or driving through tunnels/over bridges/around curves bothers me. □ all my life □ new problem
□ Riding in an airplane bothers me. □ all my life □ new problem
□ Riding in a boat bothers me. □ all my life □ new problem

Check all that apply:

□ I would describe my gait as steady.
□ I would describe my gait as unsteady.
□ I use a cane, a walker, or a wheelchair.
□ I have fainted or blacked out.
□ I have difficulty reading or writing.
□ I have difficulty with my speech.
□ I have difficulty reading in a car.
□ I have sudden spontaneous falls while standing or walking, with complete recovery in seconds or minutes. There is no recognized loss of consciousness and I remember it afterwards. (drop attacks)
□ I experience blurring of vision or double vision.
□ I have problems with depth perception.
□ I have short term memory loss.
□ I have difficulty concentrating.

Ear & Hearing History

Do you experience tinnitus (noise in your ear(s))? □ Yes □ No
If yes, what it does sound like? _____
If yes, which ear? □ Right □ Left □ Both
If yes, is it occasional or all of the time? □ Occasional □ All of the time
How bad is it? □ Not bad □ A little bothersome □ Bothersome □ Very bothersome

Do you experience pressure/fullness in your ear(s)? □ Yes □ No
If yes, which ear? □ Right □ Left □ Both

Do you ever feel any numbness or tingling in or around your ear? □ Yes □ No
If yes, which ear? □ Right □ Left □ Both
If yes, is it occasional or all of the time? □ Occasional □ All of the time

Does your hearing fluctuate with the dizzy episodes? □ Yes □ No
If yes, which ear? □ Right □ Left
If yes, was the hearing loss gradual or sudden? □ Gradual □ Sudden

Has your hearing ever improved? □ Yes □ No
Have you experienced loud noise exposure in the past? □ Yes □ No
If yes, please describe the type of noise and duration_____
Do you experience loud noise exposure at work? □ Yes □ No
If yes, how many hours per day?_____

Do you shoot guns? □ Yes □ No
If yes, do you shoot a pistol, rifle or shotgun? □ Pistol □ Rifle □ Shotgun
If yes, do you use ear protection? □ Yes □ No
What type?_____

Have you ever had any ear infections, earaches, or ear pain? □ Yes □ No
If yes, which ear? □ Right □ Left □ Both
If yes, occasionally or all of the time? □ Occasional □ All of the time

Do you have a hole in your eardrum? □ Yes □ No
If yes, which ear? □ Right □ Left

Have you had any ear operations? □ Yes □ No

If yes, please describe._____

Lifestyle

Do you drink alcohol? □ Yes □ No

If yes, how many drinks per day?_____

Do you smoke? □ Yes □ No

If yes, how many cigarettes/packs per day?_____

Have you smoked in the past □ Yes □ No

If yes, when did you quit?_____

Do you consume caffeinated beverages? □ Yes □ No

If yes, how many of the following beverages do you consume per day:

□ Cups of Coffee_____ □ Cups of cocoa _____

□ Cups of Tea _____ □ Soda/Pop _____

Do you think you consume a lot of sugar? □ Yes □ No

Do you think you consume excessive salt? □ Yes □ No

On average, how many hours of sleep do you get each night?_____

Do you feel that you have insomnia? □ Yes □ No

Do you exercise? □ Yes □ No

If yes, how many time per week?_____

If yes, for how long?_____

If yes, what type of exercise?_____

Medications

Please list all of your current medications, including hormones, birth control pills, vitamins, etc. Please include the name of the medication, dosage, and times taken per day.

Name	Dosage	# Times per Day

What medications have you taken for your dizziness?

Name	Dosage	#Times/day	Did it help?
			□ Yes □ No
			□ Yes □ No

List any allergies to medications:

_____

_____

_____

_____

Past Medical History

Please check those items you have experienced and dates:

- ☐ Low back pain
- ☐ Neck pain
- ☐ Foot Problems
- ☐ Ankle sprain/fracture
- ☐ Knee injury
- ☐ Hip injury
- ☐ Concussion
- ☐ Head injury
- ☐ Loss of consciousness
- ☐ Headaches
- ☐ Migraines
- ☐ Diabetes
- ☐ Low blood sugar
- ☐ High cholesterol
- ☐ Eye problem
- ☐ Irregular heartbeat (arrhythmia)
- ☐ Neck injury
- ☐ Whiplash
- ☐ Cardiac surgery
- ☐ TMJ
- ☐ Jaw pain
- ☐ Recent dental work
- ☐ Arthritis
- ☐ Stroke
- ☐ Seizure
- ☐ Convulsion
- ☐ Depression
- ☐ Unusual Stress
- ☐ Panic Attacks
- ☐ Treatment by a specialist
- ☐ Treatment by a psychologist
- ☐ Heart attack

Have you had any of the following? (Please check all that apply.)

- ☐ Mononucleosis
- ☐ Epstein Barr
- ☐ Syphilis
- ☐ Venereal Disease
- ☐ Exposure to HIV
- ☐ Exposure to AIDS
- ☐ Polio
- ☐ Blood transfusion in the last 5 years
- ☐ Insect Bites
- ☐ Tick Bites
- ☐ Mumps
- ☐ Measles
- ☐ Meningitis

If you have any relatives with the following, please describe the relationship:

- ☐ Migraine headaches
- ☐ Meniere's Disease
- ☐ Vertigo or Dizziness
- ☐ Balance Problems
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Diabetes
- ☐ Neurological Disease

Previous Tests

Please include the date of test, where the test was performed, and the results of the testing.

- ☐ Hearing Test
- ☐ E/VNG (Electro/Videonystagmography)
- ☐ MRI (Magnetic Resonance Imaging)
- ☐ CAT Scan
- ☐ BAER/ABR (Brainstem Auditory Evoked Response/Auditory Brainstem Response)
- ☐ OAE (Otoacoustic Emission)
- ☐ Balance Platform Test (Posturography)
- ☐ Rotary Chair Test
- ☐ VAT (Vestibular Autorotation Test)
- ☐ ECOG (Electrocochleography)
- ☐ Neck X-rays
- ☐ Carotid Artery Doppler Flow Study
- ☐ Lumbar Puncture (Spinal Fluid Study)
- ☐ Neurology Evaluation
- ☐ Complete Physical