



Name: _____ DOB: _____
Address: _____ AGE: _____
Referred By: _____ DOE: _____
Audiologist: B. Schmisser, 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 when dizzy when not dizzy
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 when dizzy when not dizzy
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)? when dizzy when not dizzy
- 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. when dizzy when not dizzy
- Walking around corners increases my dizziness. when dizzy when not dizzy
- Walking in the dark increases my dizziness. when dizzy when not dizzy
- Walking up/down stairs increases my dizziness. when dizzy when not dizzy
- Riding in elevators increases my dizziness. when dizzy when not dizzy
- Riding up/down escalators increases my dizziness. when dizzy when not dizzy
- Walking in shopping malls increases my dizziness. when dizzy when not dizzy
- 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

- | | | |
|---|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Riding in a car bothers me (in the daytime/at night) | <input type="checkbox"/> all my life | <input type="checkbox"/> new problem |
| <input type="checkbox"/> Riding or driving through tunnels/over bridges/around curves bothers me. | <input type="checkbox"/> all my life | <input type="checkbox"/> new problem |
| <input type="checkbox"/> Riding in an airplane bothers me. | <input type="checkbox"/> all my life | <input type="checkbox"/> new problem |
| <input type="checkbox"/> Riding in a boat bothers me. | <input type="checkbox"/> all my life | <input type="checkbox"/> 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))? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, what it does sound like? _____ | | |
| If yes, which ear? | <input type="checkbox"/> Right | <input type="checkbox"/> Left <input type="checkbox"/> Both |
| If yes, is it occasional or all of the time? | <input type="checkbox"/> Occasional | <input type="checkbox"/> All of the time |
| How bad is it? <input type="checkbox"/> Non-bothersome <input type="checkbox"/> A little bothersome | <input type="checkbox"/> Bothersome | <input type="checkbox"/> Very bothersome |
| | | |
| Do you experience pressure/fullness in your ear(s)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, which ear? | <input type="checkbox"/> Right | <input type="checkbox"/> Left <input type="checkbox"/> Both |
| | | |
| Do you ever feel any numbness or tingling in or around your ear? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, which ear? | <input type="checkbox"/> Right | <input type="checkbox"/> Left <input type="checkbox"/> Both |
| If yes, is it occasional or all of the time? | <input type="checkbox"/> Occasional | <input type="checkbox"/> All of the time |
| | | |
| Does your hearing fluctuate with the dizzy episodes? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, which ear? | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| If yes, was the hearing loss gradual or sudden? | <input type="checkbox"/> Gradual | <input type="checkbox"/> Sudden |
| | | |
| Has your hearing ever improved? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| | | |
| Have you experienced loud noise exposure in the past? | <input type="checkbox"/> Yes | <input type="checkbox"/> 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?	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No

List any allergies to medications:

Past Medical History

Please check those items you have experienced and dates:

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

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

- | | |
|---|--|
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Blood transfusion in the last 5 years |
| <input type="checkbox"/> Epstein Barr | <input type="checkbox"/> Insect Bites |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Tick Bites |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Exposure to HIV | <input type="checkbox"/> Measles |
| <input type="checkbox"/> Exposure to AIDS | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Polio | |

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