



Patient Information

Name _____

Address _____

City _____ St _____ Zip _____

Date of Birth _____

Social Sec # _____

Home Phone _____ Cell _____

Employer _____

Address _____

City _____ St _____ Zip _____

Work Phone _____

Occupation _____

Spouse/Parent Information

Name _____

Address _____

City _____ St _____ Zip _____

Date of Birth _____

Social Sec # _____

Home Phone _____ Cell _____

Employer _____

Address _____

City _____ St _____ Zip _____

Work Phone _____

Occupation _____

Patient Status (Check all that apply)

Full time Part time Student Single Married Other

Emergency Contact _____ Phone _____ Relationship _____

Referring Doctor _____

Primary Doctor _____

Insurance

Primary Plan Name _____

Secondary Plan Name _____

ID # _____

ID# _____

Group # _____

Group # _____

Subscriber Name _____

Subscriber Name _____

Please check if this is Worker's Comp

Patient e-mail address _____



For Dizziness and Imbalance

Name	
Age	
Today's Date	
Soc Sec #	

Send Report To:

Home Phone	
Work Phone	
Pharmacy	
Fax	
E-mail	

Your Address:

Please answer the following questions to the best of your ability. **PLEASE BRING QUESTIONNAIRE WITH YOU – DO NOT MAIL IT BACK.** Please give necessary details for yes answers. There is room at the end of each section for additional comments. **We realize that this form is long,** but when it is filled out carefully it allows us to devote more time to examining you rather than asking you related questions during your visit. Thank you.

Describe your major problem or the reason why you are seeing us.

Please describe in detail the circumstances and date in which the problem began and what were your initial symptoms and problems. Was there any stress or anxiety around the onset of the problem?

If you have spells, please describe a typical spell in as much detail as possible and describe the frequency and duration of the spells.

What do you personally think your problem is due to?



Present Illness

1) I am here because of (check all that apply):

- Dizziness (such as vertigo)
- Imbalance

My symptoms started on: _____

Check the specific symptoms that you have:

- Spinning, tumbling, cart-wheeling, tilting, or rocking
- Nausea, vomiting
- Double, blurred or jumping vision
- Headache

If yes,	Do bright lights bother you?	Y	N
	Do loud noises bother you?	Y	N
	Do strong smells bother you?	Y	N
	Does motion bother you?	Y	N

- Ear symptoms such as tinnitus (ringing in ears), fullness, hearing loss, or pain
- Others (describe): _____

Are the main symptoms constantly present, or do they appear in attacks?

If in attacks,

How often? _____

How long? _____

Do you have any warning that an attack is about to start? _____



2) Please check the symptoms which characterize your problem and grade their severity from 2 (severe), 1 (moderate), to 0 (none). Put 0 if you do not have these symptoms.

- a. Sensation or imbalance
 - Trouble with walking
 - Poor balance
 - Fall

- b. Sense of movement of the environment or of one's own body
 - Rotation (spinning, tumbling or cart wheeling)
 - Linear movement or pulling
 - Tilt

- c. Sensations not associated with movement of the environment
 - Lightheadedness or impending faint
 - Floating
 - Swimming
 - Giddiness
 - Rocking
 - Spinning inside of head
 - Fear or avoidance of being in public places

- d. Associated symptoms
 - Sweating
 - Nausea
 - Vomiting
 - Queasiness

- e. Impaired vision
 - Double vision
 - Blurred vision
 - Flashes of light
 - Jumping of vision when walking or riding in a car



Associations and Triggers

3) Are your dizziness, vertigo or imbalance, or hearing problems affected or brought on by:

Trigger	None	Some	Severely
Changes in position of the head or body (for example, turning over in bed, bending over, or looking up)			
Standing up			
Rapid head movements			
Walking in a dark room			
Walking on uneven surfaces			
Elevators			
Moving your eyes while your head is still			
Airplane, boat or car travel			
Loud noises			
Coughing, blowing the nose, or straining			
Grocery stores, tunnels, or bridges (narrow spaces)			
Wide open spaces			
Exercise			
Foods, eating or not eating, salt, monosodium glutamate (MSG)			
Heat, hot showers			
Time of day, particular seasons			
Stress			
Alcohol			
Menstrual periods (if relevant)			
Underwater diving			



4) Other questions concerning dizziness

	Yes	No
Can you bring on your dizziness voluntarily? If yes, please describe.		
Do or did you have moderate to severe motion (car or boat) sickness. If <u>yes</u> , when did it start?		
Do or did you avoid situations in which you were tumbled or spun (amusement rides, merry-go-rounds)? When did you begin?		
Has anyone observed jerking of your eyes with dizzy spells?		

5) Have you ever had: (If yes, please give details.)

	Yes	No
Infections of the ears		
Difficulty with your hearing		
Pain, fullness, popping or pressure in the ear(s)		
Pain, pins/needles, numbness, twitching, or weakness of the face		
Crossed eyes or lazy eye		

6) Ear Problems:

Have you ever had abnormal sounds in your ear? (check which applies)

- No
- Yes – the right ear
- Yes – the left ear

If yes, is it (check which apply):

- Ringing
- Hissing
- Buzzing
- Locust
- Musical
- Voices
- Crickets



Circle all that apply:

Sensitivity to noise	No	Right	Left
Fullness or pressure in ear	No	Right	Left
Pain in ear	No	Right	Left
Unable to hear clearly	No	Right	Left
Do you use a hearing aid?	No	Right	Left

7) Life Style

How much do you smoke per day? _____

Diet:

How much salt do you use on your food?

How much alcohol do you drink per week?

Do you commonly eat chocolate? Y N

Do you eat much food with MSG? Y N

Do you eat much aged cheese? Y N

What sort of work do you do (or used to do)? _____

How often do you fly on airplanes? _____

Are you presently in litigation or planning litigation about symptoms related to this visit?

Are you disabled due to your condition? _____

(Women of childbearing age only) are you:

Pregnant? Y N

Perimenopausal? Y N

How many pillows do you use to sleep at night? _____



In what position do you mainly sleep at night? (check only one)

- Back Left-down
 Stomach Any position
 Right-down

8) Injuries (check and place date of injury next to all that apply)

- None
 To ears (Date: _____)
 To head (i.e. concussion)(Date: _____)

9) Exposure (check if applicable). Do your symptoms occur with?

- Not applicable
 Loud noise (industrial)



10) Past or present health has been affected by (check all that apply):

Constitutional

- Weight Loss (15 lbs or more)
- Trouble sleeping?
 - Due to dizziness?
 - Due to depression?
 - Due to snoring?
 - Due to sleep apnea?

Cardiovascular

- Anemia
- Fainting
- Heart Problems
- High cholesterol
- High blood pressure
- Low blood pressure
- Diabetes
- Palpitations (abnormal or fast beating) of the heart

Cancer

What type and when?

Endocrine

- Low sugar (hypoglycemia)
- Thyroid disorder

Psychological

- Treatment by a psychiatrist or counselor
- Depression

- Unusual amounts of stress

Pain

- Arthritis
- Pain in back of jaw (TMJ)
- Migraine, Sinus or tension headaches
- Low back pain
- Neck pain

Immunologic

- Allergy (to what?)
- Lupus/other autoimmune disease

Breathing Problems

- Asthma
- Pneumonia
- Sinusitis
- Deviated Septum

Stomach Problems

- Ulcer
- Reflux/Hiatal Hernia
- Irritable bowel

Eye Problems (other than glasses)

- Crossed eyes, lazy eye
- Poor vision in one eye
- Cataract
- Macular Degeneration
- Double vision?

Neurological Problems

- B12 Deficiency
- Carpal Tunnel
- Memory Loss
- Meningitis
- Multiple Sclerosis
- Pins and needles, numbness (where?)
- Muscle, paralysis or weakness (where?)
- Seizures
- Speech disturbance
- Tremor or incoordination

Renal/Genitourinary

- Bladder problem
- Sexual function problem
- Kidney problem



11) Within the last 6 months have you noted:

	Yes	No
Significant loss in strength		
Significant loss of energy		
10 lb. or more weight change (if yes, up or down?)		
Significant memory loss (amnesia)		
Significant change in hand writing		
Pins and needles, numbness in arms or legs		
Muscle or joint aches (if yes, which muscle or joint?)		
Urinary incontinence (leakage of urine)		
Problems with sleeping		
Shortness of breath		
Trouble chewing_____or swallowing_____or speaking_____		
Incoordination		
Palpitations (irregular or fast beating) of the heart		
Headaches		

If you answered yes to headaches please answer the following questions.

- a) Approximately what age did the headaches begin? _____
- b) How many headaches per month do you get? _____
- c) On a scale of 1 to 10 with 10 being most severe, what is the average pain intensity of these headaches? _____



Since the onset of your headaches have you had at least 5 headaches that:	Yes	No
Lasted at least 4 hours?		
Started on one side of the head, if yes usually which side?		
Were throbbing or pulsatile in quality?		
Were severe enough to interfere with your schedule?		
Were aggravated by routine physical activity?		
Were associated with nausea and/or vomiting?		
Were aggravated by bright lights or loud noises?		

12) Surgery (please check all that apply)

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Prostate | <input type="checkbox"/> Stomach |
| <input type="checkbox"/> C-Section | <input type="checkbox"/> Cataract | <input type="checkbox"/> Knee replacement |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Epidural Injection | <input type="checkbox"/> Hip replacement |
| <input type="checkbox"/> Tonsils | <input type="checkbox"/> Sinus | <input type="checkbox"/> Back surgery |
| <input type="checkbox"/> Breast | <input type="checkbox"/> Carotid | <input type="checkbox"/> Neck surgery |
| <input type="checkbox"/> Ear | <input type="checkbox"/> Gall Bladder | |

Please explain all above with dates of surgeries:



13) Have you been exposed to any of the following? (if yes, please describe the exposure and when it occurred.)

	Yes	No
Child abuse		
Intravenous antibiotics		
Loud noises (guns, machinery, loud music)		
Drug therapy for cancer (if yes, what type)		

14) Have you had any of the following infections? (If yes, give details.)

	Yes	No
Syphilis or venereal disease		
Lyme disease		
Meningitis		
Other infections (please list		

15) Have you ever taken any of the following drugs? Mark the ones that you have taken.

- Aspirin, in large dosage
- Cisplatin (for cancer)
- Furosemide (Lasix)
- Gentamicin (antibiotic)
- Lariam or other drugs for malaria prevention
- Streptomycin (obsolete antibiotic)
- Tamoxifen (to prevent breast cancer)
- Tobramycin (antibiotic)
- Vancomycin (antibiotic)



Family History

16) Are there any family members with (check all that apply):

- Dizziness, balance or hearing symptoms:
 - Balance problems
 - Hearing loss starting at age less than 40 years old
 - Otosclerosis
 - Vertigo or dizziness
 - Meniere's syndrome
 - Symptoms like your own
- Convulsions or seizures
- Migraine headaches
- Other diseases that run in the family? (Please list)

What is your ancestry? (Some ancestries, such as French Canadian, are a little more prone to develop dizziness)



19) What other medication have you taken in the **LAST 5 YEARS** for this problem? (if don't know dosage, this is okay)

Medication Name	mg	Pills per day

20) Are you allergic to any medications and please note if drug causes rash or difficulty breathing?

21) Please check all that apply

- Have you undergone physical therapy for your condition?
- Have you undergone chiropractic for your condition?
- Have you undergone acupuncture for your condition?
- Have you attempted alternative medicines (such as Ginkgo, St. Johns Wort) for your condition?

22) Have you ever had:

	Yes	Result	When
Hearing test			
Evaluation by a neurologist			
Evaluation by an ear doctor			
Evaluation by an eye doctor			



Previous Studies

23) Have you had any of these tests? (date when done and note result if known)

Ear Tests

- | | |
|--|--|
| <input type="checkbox"/> BAER test (evoked potential test) | <input type="checkbox"/> Posturography test (balance test) |
| <input type="checkbox"/> ECOG (evoked potentials for Meniere's syndrome) | <input type="checkbox"/> Rotary Chair test (spinning test) |
| <input type="checkbox"/> ENG Caloric test (hot and cold, water or air in ear). | <input type="checkbox"/> VAT (head shake test) |
| <input type="checkbox"/> Hearing test (audiogram) | <input type="checkbox"/> Vorteq/DVA (head shake test) |
| <input type="checkbox"/> OAE (Otoacoustic emissions) | <input type="checkbox"/> VEMP (vestibular evoked myogenic potential) |

Neurological Tests

- Carotid Doppler or cerebral angiogram
- EEG (Brain wave test for seizures)
- Lumbar puncture (spinal fluid examination, spinal tap)

General Medical Tests

- Recent general medical checkup?
- Recent general blood tests
 - Blood count
 - Cholesterol
 - Glucose
 - Thyroid Tests
- Heart testing (EKG, Echo, Stress test, Holter Monitor)
- Tilt table test

X-Rays

- | | |
|---|---|
| <input type="checkbox"/> Chest X-ray | <input type="checkbox"/> Neck: X-rays, CT or MRI scan |
| <input type="checkbox"/> Ear: CT scan of inner ear (Temporal bone CT) | <input type="checkbox"/> PET scan |
| <input type="checkbox"/> Head: MRI, MRA and/or CT scan | <input type="checkbox"/> Sinus: X-rays or CT scan |

Other Important Tests:

For Office Use Only

SCORE: Total % ÷ 16 = _____

- 80% = high level of physical functioning
- 50-80% = moderate level of physical functioning
- < 50% = low level of physical functioning
- < 67% = older adults at risk for falling;



The Activities-Specific Balance Confidence (ABC) Scale

Patient Name: _____ Date: _____

For each of the following activities, please indicate your level of self-confidence by choosing a corresponding number from the following rating scale:

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
No Confidence Completely Confident

How confident are you that you will NOT lose your balance or become unsteady when you...

- 1) ...walk around the house? _____%
- 2) ...walk up or down stairs? _____%
- 3) ...bend over and pick up a shoe from the front of a closet floor? _____%
- 4) ...reach for a small can off a shelf at eye level? _____%
- 5) ...stand on your tiptoes and reach for something above your head? _____%
- 6) ...stand on a chair and reach for something? _____%
- 7) ...sweep the floor? _____%
- 8) ...walk outside the house to a car parked in the driveway? _____%
- 9) ...get into or out of a car? _____%
- 10) ...walk across a parking lot to the mall? _____%
- 11) ...walk up or down a ramp? _____%
- 12) ...walk in a crowded mall where people rapidly walk past you? _____%
- 13) ...are bumped into by people as you walk through the mall? _____%
- 14) ...step onto or off of an escalator while holding onto a railing? _____%
- 15) ...step onto or off an escalator while holding onto parcels such that you cannot hold onto the railing? _____%
- 16) ...walk outside on icy sidewalks? _____%



Dizziness Handicap Inventory

Patient Name: _____ Date: _____

Instructions: The purpose of this scale is to identify difficulties that you maybe experiencing because of your dizziness or unsteadiness.

To each question below, please place an "X" in the corresponding column: **Yes, No Sometimes.**

Answer each question as it pertains to your dizziness or unsteadiness problem only.

	Yes	No	Some-times	
1) Does looking up increase your problem?				P
2) Does walking down the aisles of a supermarket without a cart increase your problem?				P
3) Does performing more ambitious activities like sports, dancing, or household chores increase your problem?				P
4) Do quick head movements increase your problem?				P
5) Does turning over in bed increase your problem?				P
6) Does walking on the lawn increase your problem?				P
7) Does bending over increase your problem?				P
8) Because of your problem, do you restrict your travel for business or recreation?				F
9) Because of your problem, do you have difficulty getting into or out of bed?				F
10) Does your problem significantly restrict your participation in social activities?				F
11) Because of your problem, do you have difficulty reading?				F
12) Because of your problem, do you have someone accompany you when you leave home?				F
13) Because of your problem, is it difficult for you to take care of yourself bathe, dress, prepare a meal)?				F
14) Because of your problem, is it difficult for you to walk around your house in the dark?				F
15) Because of your problem, do you avoid driving your car in the daytime?				F



	Yes	No	Some-times	
16) Because of your problem, is it difficult for you to go for a walk by yourself?				F
17) Because of your problem, is it difficult for you to walk up and down stairs?				F
18) Because of your problem, do you avoid driving your car in the dark?				F
19) Does your problem interfere with your job or household responsibilities?				F
20) Because of your problem, is it difficulty for you to concentrate?				E
21) Because of your problem, do you feel frustrated?				E
22) Because of your problem, are you afraid to stay home alone?				E
23) Because of your problem, are you afraid people think you are intoxicated?				E
24) Has your problem placed stress on your relationship with members of your family or friends?				E
25) Because of your problem, are you depressed?				E
For Office Use Only				
	X4	X0	X2	
=				
Total				

For Office Use Only				
	Yes	No	Some	Total
P	(x4)=	(x0)=	(x2)=	
F	(x4)=	(x0)=	(x2)=	
E	(x4)=	(x0)=	(x2)=	
<input type="checkbox"/> 100 – 70 = Severe perception of handicap <input type="checkbox"/> 69 – 40 = Moderate perception of handicap <input type="checkbox"/> 39 – 0 = Low perception of handicap				