EarTechAudiology

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CASE HISTORY QUESTIONNAIRE

Name _____ Ph# _____ DOB _____

Your age_____ Referring Physician _____

The following questions refer to your feeling of dizziness. Please answer them "yes or no" and fill in all blanks.
PLEASE REMEMBER TO BRING THIS COMPLETED FORM BACK ON THE DAY OF YOUR TEST!

1. Please describe, in your own words, the sensation you feel without using the word "dizzy". _____
_____
_____

2. **Do you ever have any of the following sensations:**

Spinning in circles?	**YES**	**NO**
Falling to one side?	**YES**	**NO**
World spinning around you?	**YES**	**NO**

3. **The following refer to a typical dizzy spell:**

Do the dizzy spells come in attacks?	**YES**	**NO**
How often? _____		
How long? _____		
Date of first spell?_____		
Are you free from dizziness between attacks?	**YES**	**NO**
Does your hearing change with an attack?	**YES**	**NO**
Are you more dizzy in certain positions?	**YES**	**NO**
Which positions? _____		
Are you nauseated during an attack?	**YES**	**NO**
Are you dizzy even when lying down?	**YES**	**NO**
Had a recent cold or flu preceding recent dizzy spells?	**YES**	**NO**
Fullness, pressure, or ringing in your ears?	**YES**	**NO**
Pain or discharge in your ear or recent onset?	**YES**	**NO**
Trouble walking in the dark?	**YES**	**NO**
Are you better if you sit or lie perfectly still?	**YES**	**NO**

4. **The following refer to other sensations you may have:**

Do you black out or faint when you are dizzy?	**YES**	**NO**
Are you dizzy or unsteady constantly?	**YES**	**NO**
Do you have severe or recurrent headaches?	**YES**	**NO**
Any double or blurry vision?	**YES**	**NO**
Numbness in your face or extremities?	**YES**	**NO**
Weakness or clumsiness in arms, legs?	**YES**	**NO**
Slurred or difficult speech?	**YES**	**NO**
Difficulty swallowing?	**YES**	**NO**
Tingling around you mouth?	**YES**	**NO**
Spots before your eyes?	**YES**	**NO**
Jerking of arms and legs?	**YES**	**NO**
Head injury with loss of consciousness?	**YES**	**NO**
Confusion or memory loss?	**YES**	**NO**

5. **The following refer to you hearing:**

Difficulty hearing in one ear?	**L___ R ___**	**YES**	**NO**
Ringing in one ear?	**L ___ R ___**	**YES**	**NO**
Fullness in one ear?	**L ___ R ___**	**YES**	**NO**
Change in hearing when dizzy?	**L ___ R ___**	**YES**	**NO**
How? _____			
Exposure to loud noises?		**YES**	**NO**

Previous ear infection?		**YES**	**NO**
Previous ear surgery?		**YES**	**NO**
What? _____			
Family history of deafness?		**YES**	**NO**
Pain in ears?	**L ___ R ___**	**YES**	**NO**
Discharge from ears?	**L ___ R ___**	**YES**	**NO**
Hearing changing?	**L ___ R ___**	**YES**	**NO**
Better?	**L ___ R ___**	**YES**	**NO**
Worse?	**L ___ R ___**	**YES**	**NO**

6. **The following refer to habits and lifestyle:**
Is there added stress in your life recently?
Is your dizziness related to:
Moments of stress?
Menstrual period?
Overwork or exertion?
Do you feel lightheaded or have a swimming sensation when you are dizzy?
Do you find yourself breathing faster or deeper when excited or dizzy?
Did you recently change eyeglasses?

Do you drink coffee?	How much? _____	**YES**	**NO**
Do you drink tea?	How much? _____	**YES**	**NO**
Do you drink soft drinks?	How much? _____	**YES**	**NO**
Do you drink alcohol?	How much? _____	**YES**	**NO**
Do you smoke?	What & how much? _____	**YES**	**NO**

7. **Medical history:** Please list your current medical problems and length of illness. _____
_____
_____

8. **Surgery:** Please list all surgery performed and approximate dates. _____
_____

9. **Medicines:** Please list all medicines you currently take (including pain medicines, nonprescription medicines, nerve pill, sleeping and/or birth control pills). _____
_____

10. What studies have been done previously (ex: hearing, radiographs, head scans)? _____
_____

11. **Miscellaneous:**

Are you allergic to any medicines?	What? _____	**YES**	**NO**
Are you allergic to anything?	What? _____	**YES**	**NO**
Ever had weakness or faintness a few hours after eating?		**YES**	**NO**
Are you dizzy mainly when you sit or stand up quickly?		**YES**	**NO**
High blood pressure?		**YES**	**NO**
Low blood pressure?		**YES**	**NO**
Diabetes?		**YES**	**NO**
Low blood sugar?		**YES**	**NO**
Thyroid disease?		**YES**	**NO**
Asthma?		**YES**	**NO**

12. Do you have anything else to tell us about your particular problem that we haven't asked you on this questionnaire? _____
_____

_____ _____
Patient Signature Date