



Hearing & Balance Center—Medical History Questionnaire

Name _____ DOB _____ Date _____

Referring Physician _____

Primary Complaint

Please circle the symptoms you are experiencing:

Dizziness	Blacking out/Fainting	Lightheadedness	Imbalance
Falling	Vertigo (spinning)	Blurred Vision	Unsteadiness
Hearing Loss	Ringing in the ears	Ear Pain	Headaches
Nausea/Vomiting	Tingling Hands/Feet/Lips	Numb Feet	Neck Pain
Other _____			

History of Symptoms

When did the first episode occur (date): _____

Was the onset (circle one): Sudden Gradual Overnight Other _____

Are the symptoms (circle one): Getting better Staying the Same Worsening

Are the symptoms (circle one): Constant Intermittent

Are your symptoms brought on by (circle those that apply):

Sneezing Blowing your nose Loud Noises: _____

If intermittent how long do they last?

Seconds – 2 minutes 12-24 hours 48-72 hours
Other: _____

How often do they occur?

_____ per day _____ per week _____ per month _____ per year

Do position changes bring on the dizziness? Circle all that apply.

Lying down Sitting up Sit to stand Bending over Looking up

Do you use a cane, walker, or furniture/walls to keep your balance? Yes No

Does poor lighting affect your balance? Yes No

Are uneven surfaces (grass, gravel, hills) difficult to negotiate? Yes No

Have you fallen because of these symptoms? Yes No

Number of falls _____ Number of "Near-Falls" _____

Do you tend to fall in one direction? _____ If so, which direction? _____

Vision

Have you recently got new lenses? Yes No Last eye exam? _____

Has your vision changed as a result of your current symptoms? Yes No

Please describe: _____

Hearing

Do you have any of the following ear symptoms? (Please circle your answers)

Loss of hearing? Yes No (Left / Right / Both) Worsening / Fluctuating / Staying the same

Wear hearing aides? Yes No (Left / Right / Both)

Ringing/noise in your ears? Yes No (Left / Right / Both) Constant / Intermittent

Hearing Test: Where: _____ When _____

Neurologic

Do you experience any of the following? (Please circle your answers)

Doubled or blurred vision Yes No

Numbness of face/extremities Yes No

Weakness in arms/legs Yes No

Poor coordination in arms/legs Yes No

Confusion or loss of consciousness Yes No

Swallowing/Speech difficulties Yes No

Evaluation, Treatment & Testing

Other healthcare providers you have seen for these symptoms:

Surgery, procedures and/or therapy for these symptoms:

Previous tests for these symptoms

Brain or Cervical Spine CT Scan Where: _____ When _____

Brain or Cervical Spine MRI/MRA Where: _____ When _____

ENG/VNG (Vestibular Testing): Where: _____ When _____

Other _____

Allergies

If so, please describe reaction.

Seasonal Allergies: _____

Environmental Allergies (Dust / Latex): _____

Drug Allergies: _____

Health History

Hospitalizations

Date _____ Illness/Injury _____

Surgeries

Serious Injury/Illness

Women Do the symptoms seem to be related to your cycle? Yes No
If so, how? _____

Are you currently pregnant? Yes No Due Date: _____

Social

Marital Status: *(Please circle your answer)* Single Married/Divorced/Separated Widowed

Occupation: _____

Living Situation: House Apartment Condo Nursing Home Assisted Living Stairs? Yes No

Who do you live with: Spouse Family Significant Other Alone Other: _____

List your hobbies/activities: _____

Please indicate your activity level: sedentary light moderate vigorous

Habits

Caffeine: Yes No Beverages per day: _____
Smoking: Yes No Cigarettes/packs per day _____
Alcohol: Yes No Drinks per week/month: _____
Recreational drug use: Yes No

If so, what do you use? _____

_____ x day/week

For how long? _____