

EAR SPECIALISTS MEDICAL QUESTIONNAIRE

Name _____ Age _____ Sex _____ Date _____

Who requested this consultation? _____ Family Physician _____

Please complete the following as accurately as possible and if applicable.

Reason for your visit today: _____

The following refers to dizziness:

- Do you ever have any of the following sensations?
- Sense of spinning or motion Yes No
 - Falling to one side Yes No
 - World spinning around you Yes No

Referring to a typical dizzy spell:

- Do they come in attacks? Yes No
- Does anything bring on an attack? Yes No
- How often? _____
- Duration? _____
- Date of first spell _____
- Are you free of dizziness between attacks? Yes No
- Does your hearing change with an attack? Yes No
- Do your ears "ring" with an attack? Yes No
- Fullness or pressure in the ears? Yes No
- Does movement aggravate an attack? Yes No
- Which position? _____
- Do you become nauseated during an attack? Yes No
- Does lying down or rolling over in bed bring on dizziness? Yes No
- Was there a preceding cold or flu before the attack? Yes No

Referring to other sensations you may have:

- Do you black out or faint when you are dizzy? Yes No
- Do you have severe or recurrent headaches? Yes No
- Double vision? Yes No
- Numbness in your face or extremities? Yes No
- Weakness or clumsiness in arms, hands, legs? Yes No
- Slurred or difficult speech? Yes No
- Difficulty swallowing? Yes No
- Tingling around your mouth? Yes No
- History of skull fracture or concussion? Yes No
- Dizziness with standing or sitting up quickly? Yes No
- Weakness or dizziness after eating? Yes No

The following refers to your hearing and ears:

- Difficulty hearing? Right Left Both How long? _____
- "Ringing" or noise in the ear? Right Left Both How long? _____
- Fullness or pressure in the ear? Right Left Both How long? _____
- Drainage from the ear? Right Left Both
- Pain in the ear? Right Left Both
- Exposure to loud noise? Yes No
- By what? _____
- Previous ear surgery? Yes No
- What _____
- When _____
- Family history of hearing loss and whom? _____

The following refers to habits and life-style:

- Do you smoke? Yes No
- How much? _____
- Do you drink alcohol? Yes No
- How much? _____
- Do you drink coffee? Yes No
- How much? _____
- Do you drink tea? Yes No
- How much? _____
- Do you drink soft drinks? Yes No
- How much? _____
- Do you eat salty foods or add salt? Yes No
- Do you wear hearing aids? Yes No
- Substance abuse & use Yes No
- Do you have a living will regarding advance medical directives? Yes No
- Do you want information? Yes No

Medical History (high blood pressure, diabetes, etc.)

Surgery History (List all previous surgical procedures and approximate dates)

List all medications you currently take (including over the counter medications)

List allergies to any medications: _____

What studies have been done previously? (Hearing or balance tests, blood tests, head scans, etc.)

Other comments:
