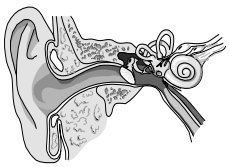
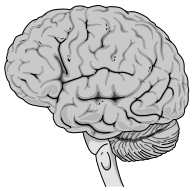


OTONEUROLOGY QUESTIONNAIRE

DIZZINESS
IMBALANCE
HEARING PROBLEMS



Chicago Dizziness and Hearing
645 N. Michigan, Suite 410
Chicago, Illinois, 60611
Voice: 312-274-0197, Fax: 312-376-8707
reception@dizzy-doc.com for scheduling
ca2@dizzy-doc.com for questions regarding treatment

Your Name: _____

Todays Date: _____

Send report to: _____

Address: _____

_____

Phone/Fax: _____

This is the first visit questionnaire for Dr. Hain. If you are scheduled to see Dr. Cherchi for the first time, please use his online questionnaire. See http://dizzy-doc.com/ has the link to Dr. Cherchi's questionnaire. This questionnaire can also be used for a first visit to our vestibular physical therapists. If you have already filled it out within the last 3 years don't do it again.

Once you are done, please return this questionnaire to us via mail or fax. This allows us to make your visit more efficient, and potentially avoid a second visit to the clinic for testing. While we will accept email attachments too, some email systems are not private, and if you do this, you are taking on a privacy risk.

Your care will be more efficient if you provide us with pertinent test results, such as CT of the head and neck, MRI of the head and neck, hearing tests including all audiograms, and tests of balance function such as VNG, VEMP or rotatory chair tests.

If you have CD's of any MRI or CT scans of your head or neck, please bring them with you so we can review them. If you do not bring them, we will request them from the institution where they were done.

Legal stuff: Please note that it is CDH's policy that we do not perform services that are outside the scope of direct medical care. For instance, unless mandated by state or federal law, we will not do paperwork related to worker's compensation, disability, functional capacity evaluations, etc., nor do we respond to attorney queries.

OTONEUROLOGY QUESTIONNAIRE

1. Chief Complaint

I am here because of (circle all that apply)

Dizziness (such as vertigo, rocking)

Imbalance (such as stumbling, falls, swaying)

Hearing Problem (hearing loss, tinnitus, fullness, hyperacusis)

Note: if you are seeing the doctor for a different reason, such as headache or another neurological problem, ask the receptionist for the proper questionnaire. We have questionnaires for headaches, tinnitus, and other neurological problems. Do not fill out multiple questionnaires – one is enough.

2. History of Present Illness

My symptoms started on: _____

Circle the symptoms that you have now.

- Spinning, tumbling, cart-wheeling, tilting or rocking
- Nausea, vomiting
- Double, blurred or jumping vision
- Light-headedness
- Ear symptoms (give details later on)
- Falls/fainting ?
- 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?

Do you have headaches too ?
migraine, sinus, neck, tension, "normal"
If yes, do you sometimes have visual auras ? Y N

OTONEUROLOGY QUESTIONNAIRE

Are your dizziness, vertigo or imbalance, or hearing problems affected by: (don't mark if not applicable or don't know)

Activity	**Worsens**	**No effect**	**Improves**
Turning over in bed			
Standing up from sitting			
Rapid head movements			
Walking in a dark room			
Motion such as airplane, boat or car travel			
Loud noises			
Bright lights			
Weather changes such as low pressure			
Coughing, blowing the nose, or straining			
Grocery stores, narrow or wide open visual spaces			
Exercise			
Driving a car			
Foods, eating or not eating, salt, monosodium glutamate (MSG)			
Particular seasons			
Stress			
Alcoholic beverages			
Menstrual periods			

Are there other triggers?:

OTONEUROLOGY QUESTIONNAIRE

REVIEW OF SYSTEMS:

Constitutional

Weight Loss (15 LB or more)

Trouble sleeping?
- Due to dizziness?
- Due to depression?
- Due to snoring ?
- Due to tinnitus ?

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

(Women only) are you
- pregnant?
- Recently pregnant ?
- Breast feeding ?
- Perimenopausal?
- Postmenopausal ?
  - With hot flashes ?

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

RESPIRATORY

Asthma

Pneumonia

Sinusitis

Deviated Septum

GASTROINTESTINAL

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

OTONEUROLOGY QUESTIONNAIRE

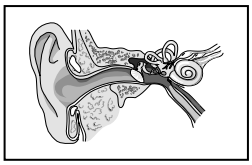
PAST MEDICAL HISTORY :

SURGERY

☐ Breast cancer	☐ Cataract	☐ Carotid	☐ C-Section
☐ Ear	☐ Epidural Injection	☐ Hysterectomy	☐ Prostate
☐ Sinus	☐ Stomach	☐ Tonsil	

Other Surgery _____

Ear Problems: Have you ever had (circle side)



Abnormal *Sounds* in ear	No	Right	Left	
If Yes, is it	Ringing?	Hissing?	Buzzing?	Locust?
Roaring ?	Musical?	Voices?	Crickets?	
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	

Injuries (circle)

to ears

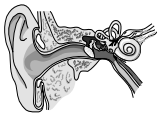
to head (for example, concussion -- please list ALL, with DATES)

Exposures (circle)

Loud noise (industrial) Toxins

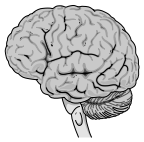
PAST MEDICAL HISTORY: PREVIOUS STUDIES

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



EAR TESTS:

- ☐ ABR or BAER test (evoked potential test)
- ☐ ECOG (evoked potentials for Meniere's syndrome)
- ☐ ENG Caloric test (hot and cold, water or air in ear),
- ☐ Hearing test (audiogram)
- ☐ Posturography test (balance test on a platform)
- ☐ Rotatory Chair test (spinning test)
- ☐ VEMP (vestibular evoked myogenic potential)
- ☐ VHIT (video "head impulse test")



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 and MRI scans

- ☐ Chest X-ray
- ☐ Ear: CT scan of inner ear (Temporal bone CT)
- ☐ Head: MRI, MRA, MRV and/or CT scan
- ☐ Neck: X-rays, CT or MRI scan
- ☐ Sinus: X-rays or CT scan

Other Important Tests:

OTONEUROLOGY QUESTIONNAIRE

SOCIAL HISTORY

Smoking history: Do you smoke, have you smoked in the past ?

How much alcohol do you *drink per week*?

How much *salt* do you use on your food?

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?

Do you drive ?

How many pillows do you use to sleep at night?

None One Two More than two

In what position do you mainly sleep at night? (circle)

Back Stomach R-Side L-Side Any

OTONEUROLOGY QUESTIONNAIRE

FAMILY HISTORY

Are there any **family members** with (circle, list):

Dizziness, balance or hearing symptoms:

Balance problems

Hearing loss starting at age < 40

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 ethnicity ? (some genetic populations, such as French Canadian are more prone to develop dizziness than others)

MEDICATIONS

10a. What are your current medications, include hormones, allergy shots, birth control pills, vitamins, etc. (Name and amount/day)?

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

10b. What other medications have you taken in the last 5 years, for this problem or others?

1.
2.
3.
4.
5.

10c. Have you undergone physical therapy for your condition? ☐
Chiropractic treatment? ☐
Acupuncture? ☐
Alternative medicines (such as Ginkgo, St. Johns Wort?) ☐

10d. **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)
Intravenous antibiotics --
- ☐ Gentamicin (antibiotic)
- ☐ Kanamycin (antibiotic)
- ☐ Streptomycin (obsolete antibiotic)
- ☐ Tobramycin (antibiotic)
- ☐ Vancomycin (antibiotic)

☐ Malaria prevention drugs (chloroquine, Larium)
☐ Tamoxifen (to prevent breast cancer)