

We have developed a questionnaire to help us determine whether you might be experiencing hearing loss. Please answer each question as thoroughly as possible. If you would like to add additional information, please feel free to do so.

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Date \_\_\_\_\_

- Yes  No Do you ever experience lightheadedness or a "swimming" sensation in your head?
- Yes  No Do you become dizzy if you turn your head quickly?
- Yes  No Do objects ever appear to spin or turn around you?
- Yes  No Do you ever feel like you are turning or spinning while everything else remains stationary?
- Yes  No Have you ever felt nauseated or vomited during an episode of dizziness?
- Yes  No Do you experience pressure in your  head or  ears?  Left ear  Right ear  Both
- Yes  No Is your dizziness  constant or does it occur as  attacks?
- Yes  No If your dizziness occurs as attacks, please answer the following questions:  
 How often do the attacks occur? \_\_\_\_\_  
 How long do the attacks last? \_\_\_\_\_  
 When was the last attack? \_\_\_\_\_  
 When did you first start having attacks? \_\_\_\_\_
- Yes  No Does rolling over in bed make you dizzy?  
 To your  left side,  right side or on  your back? (Check one)
- Yes  No Do you become dizzy when  bending over or  sitting up? (Check one)
- Yes  No Do fluorescent lights make you dizzy?
- Yes  No Have you ever seen a neurologist? If yes, when? \_\_\_\_\_ Who? \_\_\_\_\_
- Yes  No Do you lose your balance while walking in the dark?  
 If yes, do you sway to the  left or  right? (Check one)
- Yes  No Have you found anything that will stop your dizziness? If yes, what? \_\_\_\_\_
- Yes  No Have you found anything that makes your dizziness worse? If yes, what? \_\_\_\_\_
- Yes  No What causes an episode of dizziness to start or worsen? (Check one)  
 Exertion  Hunger  Menstrual Cycle  Stress  Movement  
 Other: \_\_\_\_\_
- Yes  No Do you have headaches?
- Yes  No Do you have a family history of headaches or migraines?  
 If yes, which family member? \_\_\_\_\_
- Yes  No Do you have difficult hearing?  Left  Right  Both
- Yes  No Do you hear noises (such as ringing) in your ears?  Left  Right  Both  
 What do the noises sound like? \_\_\_\_\_
- Yes  No Do you wear hearing aids?  Left  Right  Both  
 How long have you worn hearing aids? \_\_\_\_\_  
 Where were your hearing aids obtained or purchased? \_\_\_\_\_  
 Is one ear worse?  Left  Right

- Yes  No Do you ever experience discharge from your ears?
- Yes  No Have you ever had ear surgeries or implants?  
If yes, when? \_\_\_\_\_ Where? \_\_\_\_\_  
What type of ear surgery? \_\_\_\_\_
- Yes  No Have you ever had a hole in your eardrum or PE tubes?  
When was the surgery performed? \_\_\_\_\_
- Yes  No Have you had chicken pox, shingles or other rashes? When? \_\_\_\_\_ Where? \_\_\_\_\_
- Yes  No Have you ever been treated for cancer? If yes, when and what type? \_\_\_\_\_
- Yes  No Have you ever been in an automobile accident? If yes, when? \_\_\_\_\_
- Yes  No Have you ever fallen or hit your head? If yes, when? \_\_\_\_\_
- Yes  No Do you smoke or use tobacco in any form? If yes, how much per week? \_\_\_\_\_
- Yes  No Do you use alcohol? If yes, how many drinks per week? \_\_\_\_\_
- Yes  No Do you use caffeine (coffee, tea, soda, etc.)? If yes, how many cups per week? \_\_\_\_\_
- Yes  No Have you been camping or spent a significant amount of time outdoors in the last six months?
- Yes  No Have you been on a cruise or an airplane in the last six months?
- Yes  No Were you exposed to irritating fumes, paints or other materials recently or in the past?
- Yes  No Have you ever been exposed to loud noises at work or home?  
What? \_\_\_\_\_ When? \_\_\_\_\_
- Yes  No Do loud noises bother you?
- Yes  No Are you diabetic?

**Have you ever experienced:**

- Yes  No Blacking out or loss of consciousness or confusion?
- Yes  No  Double vision or  blindness?  Constant or  episodes (Check one)
- Yes  No Numbness of face?  Constant or  episodes (Check one)
- Yes  No Numbness?  Constant or  episodes (Check one)
- Yes  No  Weakness or  clumsiness of  arms or  legs?  Constant or  episodes (Check one)
- Yes  No Difficulty speaking?
- Yes  No Rashes?

**List all medications you are currently taking (or provide a list)** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please provide **any additional relevant information** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had surgeries for any of the following?  Eyes  Back  Neck  Knees  Feet  Heart

- Yes  No Have you been diagnosed with any other illness or have a family history of any other illnesses?  
If yes, please list \_\_\_\_\_
- Yes  No Have you seen other physicians for your complaints, other than the one who referred you for this evaluation?  
If yes, when? \_\_\_\_\_ If yes, where were you seen? \_\_\_\_\_

**PLEASE SIGN RELEASE FORM FOR RECORDS TO BE OBTAINED**