Central Florida HEARING SERVICES

Informative. Compassionate. Personalized.

We have developed a questionnaire to help us determine what symptoms your are experiencing . 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