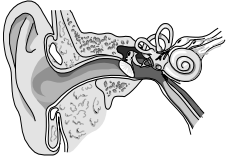
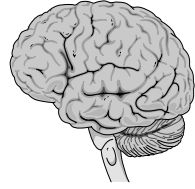


OTONEUROLOGY QUESTIONNAIRE



for patients with
 DIZZINESS
 IMBALANCE
 HEARING PROBLEMS



Chicago Dizziness and Hearing
 645 N. Michigan, Suite 410
 Chicago, Illinois, 60611

NAME	
AGE	
TODAY'S DATE	
SOCIAL SEC #	

SEND REPORT TO (besides self):

HOME PHONE #	
WORK PHONE #	
PHARMACY #	
PATIENT'S FAX	
Email (for appt reminders)	

YOUR ADDRESS:

Sex: M F Birthdate: / / Single Married Widowed Separated Divorced

Patient Employed by: _____

Business Address: Street _____ City _____ State _____ Zip _____

Primary Insurance: _____ Card Holder Name: _____

Secondary Insurance: _____ Card Holder Name: _____

- Sign below to indicate that:
1. We offered you a copy of our Privacy Policy statement for your review
 2. We have your permission to ask your doctor for records related to the reason for this appointment
 3. I hereby authorize the release of any information needed by my carrier to process the claim. I understand that I am financially responsible for all charges; these may include, but are not limited to, deductibles, co-pays, and "non-covered services".
 4. We have your permission to use video material of your eye (where you cannot be recognized) in research or educational works.

Signature _____

Please answer the following questions and bring the answers to your appointment. There is room at the end of each section for additional comments. Please give necessary details for "yes" answers. We realize that this form is long, but when it is filled out carefully it allows us to devote more time to examining you.

OTONEUROLOGY QUESTIONNAIRE

Associations

2. **Are your dizziness, vertigo or imbalance, or hearing problems affected on by**

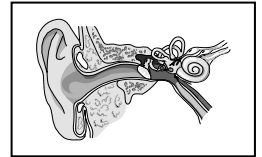
Activity	Worsens	No effect	Improves	Not Applicable
Changes in position of the head or body (for example, turning over in bed) 				
Standing up				
Rapid head movements				
Walking in a dark room				
Elevators 				
Airplane, boat or car travel   				
Loud noises 				
Coughing, blowing the nose, or straining				
Grocery stores, narrow or wide open spaces				
Exercise 				
Driving a car 				
Foods, eating or not eating, salt, monosodium glutamate (MSG)				
Heat, hot showers 				
Time of day, particular seasons				
Stress 				
Alcoholic beverages				
Menstrual periods				
Underwater Diving 				

Are there other triggers?:

OTONEUROLOGY QUESTIONNAIRE

3. Ear Problems: Have you ever had (circle side)

Abnormal <i>Sounds</i> in ear	No	Right	Left
If Yes, is it Ringing? Hissing? Buzzing? Locust?			
Roaring ? Musical?	Voices?	Crickets?	
<i>Sensitivity</i> to Noise	No	Right	Left
<i>Fullness</i> or pressure in ear	No	Right	Left
<i>Pain</i> in ear	No	Right	Left
<i>Unable to hear</i> clearly	No	right	Left
Do you use a hearing aid?	No	Right	Left



4. Life Style

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 ?

(Women only) are you pregnant?

Recently pregnant ?

Breast feeding ?

Perimenopausal?

Postmenopausal ?

With hot flashes ?

How many pillows do you use to sleep at night?

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

Back Stomach Right-down Left-down Any

5. Injuries (circle)

to ears

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

OTONEUROLOGY QUESTIONNAIRE

6. **Exposure** (circle)

Loud noise (industrial)

Toxins

7. Past or present health has been affected by (circle)

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

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

BREATHING PROBLEMS

Asthma

Pneumonia

Sinusitis

Deviated Septum

STOMACH PROBLEMS

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

8. SURGERY

- | | | | |
|--|---|---------------------------------------|------------------------------------|
| <input type="checkbox"/> Breast cancer | <input type="checkbox"/> Cataract | <input type="checkbox"/> Carotid | <input type="checkbox"/> C-Section |
| <input type="checkbox"/> Ear | <input type="checkbox"/> Epidural Injection | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Sinus | <input type="checkbox"/> Stomach | <input type="checkbox"/> Tonsil | |

Other _____

FAMILY HISTORY

9. 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, Lariam)
- Tamoxifen (to prevent breast cancer)

PREVIOUS STUDIES

11. 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)
- OAE (Otoacoustic emissions)
- Posturography test (balance test)
- Rotatory Chair test (spinning test)
- VEMP (vestibular evoked myogenic potential)



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 and/or CT scan
- Neck: X-rays, CT or MRI scan
- PET scan
- Sinus: X-rays or CT scan

Other Important Tests: