EAR SPECIALISTS OF OMAHA

MEDICAL QUESTIONNAIRE

Name: _____ Age: _____ Sex: _____ Date: _____

Who requested this consultation? _____ Family Physician: _____

Please complete the following as accurately as possible, 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 or legs? ☐ YES ☐ NO

Slurred or difficult speech? ☐ YES ☐ NO

Difficulty swallowing? ☐ YES ☐ NO

Tingling around your mouth? ☐ YES ☐ NO

History of skull fraction 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 lifestyle:

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

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 _____

9202 West Dodge Road, Suite 200, Omaha, Nebraska 68114 | PHONE: **402.933.3277** • TOLL-FREE: **800.228.3277** • FAX: **402.933.2216**

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