



Patient Questionnaire

Date: _____
Name: _____
DOB: _____
Age: ____
Sex: ____
SS#: _____
Current Medications: _____
Medication Allergies: _____

Please answer the following questions to the best of your ability. These questions have been designed to give your doctor a thorough overview of all the systems that may be involved in your disorder.

1) Please check if you have experienced any of the following problems.

- vertigo
- dizziness
- imbalance
- tinnitus
- headaches
- migraines
- recent visual changes
- fluctuations in vision
- glaucoma
- macular degeneration
- double vision
- concussion / head injury
- stroke
- intracranial hemorrhage
- dysequilibrium
- short-term memory loss
- lightheadedness
- facial paralysis
- Attention Deficit Disorder
- dyslexia
- Central Auditory Processing Disorder
- anxiety/panic attacks
- cervical neck pain
- low Back Pain
- depression
- irregular Menstruation

2) How would you best describe your symptoms?

- Symptoms fluctuate
- Symptoms are constant
- Symptoms are intermittent
- Very rarely

3) Is there a time of year that they most commonly occur?

- spring
- summer
- fall
- winter

no seasonal variation

4) Do your symptoms worsen with allergies?

yes

no

5) Do they worsen with your menstrual cycle (women only)?

yes

no

6) Please check if you have trouble with any of the following activities.

Rapid head movements?

Reading?

Riding in a car?

In grocery stores?

In malls or open places?

Driving at night?

Walking up or down stairs?

Car sickness?

Sleeping?

7) Have you had any falls in the past year?

none

1-2

3-4

5-6

>6

8) Have you suffered any injuries as a result of a fall?

fracture

lacerations

herniated disc

hip fracture

bruising of extremities

concussion

9) Do loud noises seem to bother you?

yes

no

10) Do you have hearing loss?

one ear

both ears

none

don't know

11) Severity of hearing loss:

Mild

Moderate

Severe

Fluctuant

12) Duration of problems with your hearing:

< 1 year

1-3 years

3-5 years

>5 years

13) Does your hearing fluctuate?

yes

no

14) Do you have ringing in the ears or tinnitus?

- constant
- sometimes
- none

15) Do you have complaints of?

- short-term memory loss
- trouble with concentration
- difficulty focusing on a task
- Distractibility
- Difficulty with sleep
- Coordination
- Emotional Fluctuation

16) Have you ever been diagnosed with:

- Meniere's disease
- Labyrinthitis
- Stroke
- TIA's
- Brain hemorrhage
- Encephalitis
- Meningitis
- Migraine headaches
- Sinus Headaches
- Recurrent Sinusitis
- ADD/ADHD/Autism
- Central processing disorder
- Dyslexia
- Anxiety disorder (panic attacks)
- Depression
- Irritable Bowel syndrome
- Lumbar Disc Disease
- Ulcerative Colitis
- Crohn's disease
- Thyroiditis
- Autoimmune Disease
- Lupus
- Sjogren's Syndrome
- Adult Onset (Type 2) Diabetes Mellitus
- Parkinson's Disease
- TMJ syndrome
- Fever blisters
- Shingles
- Chicken Pox
- Genital Herpes
- Chancre Sores
- Epstein-Barr
- Cytomegalovirus
- Lyme's Disease
- Heavy metal Toxicity
- Other significant disease _____

17) Does your family have a history of:

- Meniere's disease
- Labyrinthitis
- Stroke
- TIA's
- Brain hemorrhage
- Cancer _____
- Encephalitis

- Meningitis
- Migraine headaches
- ADD/ADHD/Autism
- Central processing disorder
- Dyslexia
- Anxiety disorder (panic attacks)
- Depression
- Irritable Bowel syndrome
- Ulcerative Colitis
- Crohn's disease
- Thyroiditis
- Autoimmune Disease
- Lupus
- Sjogren's Syndrome
- Adult Onset (Type 2) Diabetes Mellitus
- Parkinson's Disease
- TMJ syndrome
- Arthritis
- Heavy Metal Toxicity
- Polycystic Ovarian Syndrome
- Infertility

18) Has this problem caused you to miss work?

- none
- Days
- 1-2 weeks
- 2-4 weeks
- 1-3 months
- 3-6 months
- >6 months

19) Which of the following professionals have you consulted for your problem?

- Family doctors
- Ophthalmologist
- Optometrist
- ENT's
- Neurologists
- Psychiatrists
- Psychologists
- Naturopathic Physician
- Occupational Therapists
- Physical Therapists
- Massage Therapists
- Vision Therapists
- Other _____

20) Have you received any of the following as a result of your symptoms?

- MRI scan of your brain. How many? ____
- MRI of neck.
- CT of the brain.
- EEG.
- Hearing test (audiogram).
- Eye Exams. How many? _____
- Other dizzy testing (ENG)

21) How do you rate your problem on a scale of 1-10? (minor to severe)

- ___ Affect on everyday life?
- ___ Limitations of ability to work?
- ___ On a good day?
- ___ On a bad day?

22) Please list all hospitalizations and surgeries and dates:

23) Have you ever had an eye exam? ____ If so, date of last exam: _____

24) Please indicate with a check mark the extent to which you experience the following over the past two weeks:

	Not at all	Just a little	Quite a bit
Feeling worried, guilty or anxious	_____	_____	_____
Feeling tense, uptight or nervous	_____	_____	_____
Feeling in a low mood, sad or depressed	_____	_____	_____
Having difficulty concentrating or focusing	_____	_____	_____
Feeling "stressed out"; unable to cope	_____	_____	_____
Being forgetful, having memory problems	_____	_____	_____
Making mistakes when performing common tasks or chores	_____	_____	_____
Not thinking as quickly or clearly as before	_____	_____	_____
Being angry, losing your temper	_____	_____	_____
Not having any enjoyment in life	_____	_____	_____

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient