

# EVMS HEARING AND BALANCE CENTER HEARING AND BALANCE HISTORY

Patient Name \_\_\_\_\_ Date \_\_\_\_\_ DOB \_\_\_\_\_

## Hearing:

1. Do you have any hearing problems?  No  Yes  Right ear  Left ear
2. Has your hearing loss been?  Gradual  Sudden  Fluctuating
3. How long have you had a hearing problem? \_\_\_\_\_
4. Does anyone in your family have hearing loss?  No  Yes Who? \_\_\_\_\_
5. Do you own hearing aids?  No  Yes  Right ear  Left ear
6. Do you have fullness or pressure in your ears?  No  Yes
7. Have you been exposed to loud noise?  No  Yes When? \_\_\_\_\_
8. Do you have a history of ear infections?  No  Yes

## Tinnitus (Head noise):

1. Do you have noise in your ears or head?  No  Yes  Right ear  Left ear
2. If yes, is the noise:  Constant  Periodic  Pulsating  Low pitch  High pitch

## Dizziness:

1. Do you have dizziness, vertigo, or unsteadiness?  No  Yes
2. **Choose only one** of the following as to which one **BEST** describes your dizziness:
  - A sensation of movement of the room: spinning, tilting, or wave-like movement
  - Lightheadedness or feeling that you are going to faint
  - Loss of balance
  - Disassociation, disorientation, or loss of attachment with the world
3. When did the dizziness first occur? \_\_\_\_\_
4. Is the dizziness?  Constant, all day long more or less  In episodes or attacks
5. If the dizziness comes in attacks, how often do the attacks occur? \_\_\_\_\_  
\_\_\_\_\_
6. If the dizziness comes in attacks, how long do the attacks last? \_\_\_\_\_  
\_\_\_\_\_
7. When you are "dizzy" do you experience any of the following sensations? **You may check as many yes responses as necessary.**
  - No  Yes 1. Blacking out or loss of consciousness.
  - No  Yes 3. Objects or the room spinning?
  - No  Yes 4. Sensation that you are turning or spinning inside?

MD Initials \_\_\_\_\_

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- No  Yes 5. Loss of balance when walking?
  - No  Yes 6. Lightheadedness or giddiness?
  - No  Yes 7. Headache or Pressure in the head?
  - No  Yes 8. Have you ever fallen because of your dizziness?
  - No  Yes 9. Nausea or vomiting?
  - No  Yes 10. Changes in vision, flashes of light, double vision, blind spots?
  - No  Yes 11. Numbness or weakness in the arms or legs, or changes in speech?
  - No  Yes 12. Pain or tightness in the neck
8. What factors provoke the dizziness or make the dizziness worse?  Driving  Looking up  Getting up quickly  Rolling over in bed  Turning my head  Activity  Stress  Other \_\_\_\_\_
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9. Does your hearing change when the dizziness occurs?  No  Yes  Right ear  Left ear
10. Do you have a change in head noise during the spells?  No  Yes  Right ear  Left ear
11. Do you have pressure or fullness in your ears during the spells?  No  Yes  Right  Left
12. Are you completely free of dizziness between attacks?  No  Yes

## Neurologic History:

- 1.  No  Yes Have you ever been diagnosed with a head or neck injury?
- 2.  No  Yes Do you or anyone in your family have a history of migraine?
- 3.  No  Yes Have you ever had a seizure, multiple sclerosis, mini-stroke or stroke?
- 4. Have you experienced any of the following symptoms?
  - No  Yes 1. Double vision, blurred vision or blindness
  - No  Yes 2. Numbness or weakness of face, arms or legs
  - No  Yes 5. Unusual clumsiness
  - No  Yes 6. Confusion or loss of consciousness
  - No  Yes 7. Difficulty with speech or swallowing
  - No  Yes 9. Pain in the neck or shoulder
- 3. Have you recently had any of the following?
  - No  Yes 1. Hearing test?
  - No  Yes 2. MRI or CT of the head or neck?
  - No  Yes 3. Balance Testing?
  - No  Yes 4. Lumbar puncture to test spinal fluid?
  - No  Yes 5. Blood tests for dizziness
  - No  Yes 6. Evaluation by a neurologist?
  - No  Yes 7. Evaluation by an ear doctor?
  - No  Yes 8. EEG (brain wave test)
  - No  Yes 9. Heart Evaluation (EKG, Holter monitor, ECHO, Stress test, other)
  - No  Yes 10. Carotid Doppler study (test of blood flow in neck)

MD Initials \_\_\_\_\_