The Hearing Center of Lake Charles, Inc.
Hear today. Hear tomorrow.

The office of Dr. Ram Nileshwar, Au.D., CCC-A, FAAA
Board Certified in Audiology

Patient Questionnaire

Patient Name _____ Date _____ /_____ /_____
MM DD YYYY

Equilibrium disorders may appear with a variety of symptoms. Some individuals may experience dizziness or vertigo while others may have imbalance or unsteadiness. Please spend a few minutes answering the questions regarding your history and symptoms. Answer the questions to the best of your ability but please be assured that how you answer will not affect your evaluation.

How or when did your problem first occur? _____

How long did it last? _____

I. Do you experience any of the following sensations? Please read the entire list first. Then put an "x" in either the first box for YES or the second box for NO to describe your feelings most accurately.

☐ YES ☐ NO Do you experience motion sickness, airsickness or seasickness?

☐ YES ☐ NO Did you have motion sickness as a child?

☐ YES ☐ NO Do you have a family history of motion sickness? ☐ parent? ☐ sibling? ☐ child?

☐ YES ☐ NO Do you have migraine/headaches?

☐ YES ☐ NO Were you exposed to any solvents, chemicals, etc.?

☐ YES ☐ NO Did you have any injuries to your head? When? _____

☐ YES ☐ NO If you received a head injury, were you unconscious?

☐ YES ☐ NO Have you ever had a neck injury?

☐ YES ☐ NO Have you ever fallen? How many times? _____

☐ YES ☐ NO Where? Inside the home? _____ Outside the home? _____

☐ YES ☐ NO Are you afraid of falling?

☐ YES ☐ NO Do you take any medications regularly? (e.g., tranquilizers, oral contraceptives, barbiturates, antibiotics, thyroid) List them _____

_____

☐ YES ☐ NO Do you use alcohol?

☐ YES ☐ NO Do you smoke? How much? _____

II. If you have dizziness, please check the box YES and fill in the blank spaces. If you do not experience dizziness, please go to the next section (III).

☐ YES ☐ NO My dizziness is constant? If you answered yes, please go to section III.

☐ YES ☐ NO My dizziness comes in attacks? How often? _____

☐ YES ☐ NO Are you completely free of dizziness between attacks?

☐ YES ☐ NO Do you have any warning that the attack is about to start?

☐ YES ☐ NO Is the dizziness provoked by head/body movement? If so, which direction? _____

☐ YES ☐ NO Is the dizziness worse at any particular time of the day? If so when? _____

☐ YES ☐ NO Does anything stop your dizziness or make it better? What? _____

☐ YES ☐ NO Does anything make your dizziness worse? What? _____

☐ YES ☐ NO Do you know what will precipitate an attack? What? _____

☐ YES ☐ NO Do you know any possible cause of your dizziness? What? _____

III. Do you experience any of the following sensations? Please read the entire list first then check the box for either YES or NO to describe your feelings most accurately.

☐ YES ☐ NO Lightheadedness?

☐ YES ☐ NO Swimming sensation in the head?

☐ YES ☐ NO Blacking out or loss of consciousness?

☐ YES ☐ NO Objects spinning or turning around you?

☐ YES ☐ NO Sensation that you are turning or spinning inside, with outside objects remaining stationary?

☐ YES ☐ NO Tendency to fall...to the right or left?

☐ YES ☐ NO Tendency to fall...forward or backward?

☐ YES ☐ NO Loss of balance when walking...veering to the right?

☐ YES ☐ NO Loss of balance when walking...veering to the left?

☐ YES ☐ NO Do you have trouble walking in the dark?

☐ YES ☐ NO Do you have problems turning to one side or the other?

☐ YES ☐ NO Nausea or vomiting?

☐ YES ☐ NO Pressure in the head?

IV. Have you ever experienced any of the following symptoms? Please check the box for either YES or NO and circle if Constant or if in Episodes.

☐ YES ☐ NO	Double vision?	Constant	In Episodes
☐ YES ☐ NO	Blurred vision or blindness?	Constant	In Episodes
☐ YES ☐ NO	Spots before your eyes?	Constant	In Episodes
☐ YES ☐ NO	Numbness of face, arms or legs?	Constant	In Episodes
☐ YES ☐ NO	Weakness in arms or legs?	Constant	In Episodes
☐ YES ☐ NO	Confusion or loss of consciousness?	Constant	In Episodes
☐ YES ☐ NO	Difficulty in swallowing?	Constant	In Episodes
☐ YES ☐ NO	Tingling around the mouth?	Constant	In Episodes
☐ YES ☐ NO	Difficulty speaking?	Constant	In Episodes

V. Do you have any of the following symptoms? Please check the box for either YES or NO and circle the ear involved.

☐ YES ☐ NO Difficulty in hearing? ☐ Both Ears ☐ Right Ear ☐ Left Ear

☐ YES ☐ NO When did this start? _____ Is it getting worse? _____

☐ YES ☐ NO Does the hearing change with your symptoms? If so, how?_____

☐ YES ☐ NO Noise in your ears ☐ Both Ears ☐ Right Ear ☐ Left Ear

☐ YES ☐ NO Describe the noise _____

☐ YES ☐ NO Does the noise change with your symptoms? If so, how? _____

☐ YES ☐ NO Does anything stop the noise or make it better? _____

☐ YES ☐ NO Fullness or stuffiness in your ears? ☐ Both Ears ☐ Right Ear ☐ Left Ear

☐ YES ☐ NO Does this change when you are dizzy? _____

☐ YES ☐ NO Pain in your ears? ☐ Both Ears ☐ Right Ear ☐ Left Ear

☐ YES ☐ NO Discharge from your ears? ☐ Both Ears ☐ Right Ear ☐ Left Ear