South Shore Hearing Center

"For a Difference You Can Hear" – Since 1982

541 Main Street, Suite 418, South Weymouth, MA 02190 – 781 337 6860

ENG/VNG Questionnaire

Patient Information

Name:_____Title Dr. Mr. Mrs. Ms. Miss Other____
Date of Birth: _____ Occupation:_____
Address: _____
City:_____ State: _____ Zip code: _____
Referring Physician: _____
Family Physician, if different:_____

Initial Problem

Please describe the problem(s) you are seeking help with:_____
_____
When did the problem(s) begin?_____
What were the initial symptoms and circumstances?_____
_____
What have you been told your problem is due to?_____
_____
What do *you* think your problem is due to? _____
_____
Please circle the following words that describe your problem(s)

Giddy	Lightheaded	Off-balance	Disoriented
Spinning	Tumbling	Dizziness	Tumbling
Rocking	Tilting	Other _____	

Have these symptoms improved since the problem(s) began? _____
_____
How often does the problem(s) occur? _____
When are the symptoms mostly present? _____walking _____standing _____sitting
_____lying down _____movement from one position to another _____anytime _____ all the time

Initial Problem (Cont.)

	Yes	**No**	**Yes, during a spell**
Do you have difficulty with balance?	____	____	_____
Have you fallen?	____	____	_____
Do you ever feel pulled to the ground?	____	____	_____
Do you feel like you are about to faint?	____	____	_____
Have you fainted?	____	____	_____
Do you have nausea and vomiting?	____	____	_____

Are the symptoms made worse by:

	Yes	No
Lying down or rolling over in bed?	____	____
Sitting up or standing up?	____	____
Exercise?	____	____
Reaching up or bending?	____	____
Coughing, sneezing, or straining?	____	____
Loud noises?	____	____
Turning your head while walking?	____	____
Automobile rides?	____	____
Windshield wipers?	____	____
Reading?	____	____
Walking in the dark or on uneven surfaces?	____	____
Supermarket aisles, malls, tunnels, bridges, heights?	___	____
Restaurants and movie theaters?	____	____
Menstrual cycle?	____	____

What other specialists have you seen regarding the problem(s)?_____
_____
_____

What types of tests have they ordered and what were the results? _____
_____
_____
_____
_____
_____
_____

Have you been prescribed any medication for the problem(s)? What kind? Has it helped?
_____
_____
_____
_____

General Health Questions

Please list all current medications, both prescription and over-the-counter, and why you take them.
_____
_____
_____
_____
_____
_____

General Health Questions (cont.)

	Yes	No
Do you suffer from headaches?	___	___
Does the pain tend to be on one side of your head?	___	___
Which side, where on head? _____		
Are the headaches accompanied by nausea and/or vomiting?	___	___
Do any food and drinks cause a headache?	___	___
If yes, please list:_____		
How often do you get headaches?_____		
How long do the headaches last?_____		
Do you take medication for headaches?	___	___

Please list:_____

If female,

are headaches associated with your menstrual cycle? ___ ___

Is there an event that always happens before getting a headache, such as

Seeing spots or jagged lines, hearing sounds, etc… ___ ___

Please describe_____

_____

Have you ever been diagnosed with migraine? ___ ___

Do you have any family members that have migraine? ___ ___

Do you suffer from motion sickness/sensitivity? ___ ___

When did problems begin?_____

What provokes motion sickness?_____

Do you have any problems with your vision? ___ ___

Please explain _____

Do you have double vision? ___ ___

Did you wear an eye patch as a child? ___ ___

Which eye?_____

Have you ever had eye surgery? ___ ___

For what reason, which eye?_____

_____

Have you ever had a panic attack? ___ ___

How many/how often?_____

What triggers a panic attack?_____

Do you ever feel dizzy during a panic attack? ___ ___

Do you ever feel panicked during an episode of dizziness? ___ ___

Have you ever been diagnosed with an anxiety disorder? ___ ___

Do you take medication for anxiety or panic? ___ ___

Please list:_____

_____

Do you have any problems with circulation? ___ ___

Have you ever had a stroke? ___ ___

When?_____

Have you ever been diagnosed with a

blocked or clogged artery? ___ ___

Do you have problems with the feeling in your feet? ___ ___

Have you ever been diagnosed with neuropathy? ___ ___

Do you know the cause?_____

Have you ever had a head injury? ___ ___

When?_____

Please describe incident_____

_____

_____

Do you have any disorder of the central nervous system? ___ ___

If so, what?_____

How is it being treated?_____

_____

Thank you for taking the time to fill out this questionnaire.
You responses will assist us in better serving you and your needs.