West Coast
Hearing and Balance Center
301 S. Moorpark Rd.
Thousand Oaks, CA 91361
P: 805-379-0824 F: 805-379-0611

Patient Name: _____ Date of Birth: _____

HEARING SECTION:

YES or **NO** I think I have hearing loss but it is not confirmed by testing.

YES or **NO** I have a documented hearing loss.
If yes please circle one of the following,
- **Both ears? Only right ear? Only left ear?**

YES or **NO** My hearing changes from day to day.

YES or **NO** I have ringing or noise (tinnitus) that is, **constant?** Or **intermittent?**
If yes please circle one of the following,
- **Both ears? Only right ear? Only left ear?**

YES or **NO** I have a feeling of fullness or pressure in my ear(s) that is, **constant?** Or **intermittent?**
If yes please circle one of the following,
- **Both ears? Only right ear? Only left ear?**

YES or **NO** I have pain in my ears that is, **constant?** Or **intermittent?**
If yes please circle one of the following,
- **Both ears? Only right ear? Only left ear?**

YES or **NO** I have frequent ear infections/drainage from my ear(s) that is, **constant**? Or **intermittent?**
If yes please circle one of the following,
- **Both ears? Only right ear? Only left ear?**

YES or **NO** I have been exposed to loud noise
If yes please circle all that may apply,
- **Power tools Construction/factory work Hunting?**
  Loud music Military service Artillery

DIZZY SECTION:

When did your dizziness first occur? _____

YES or **NO** My symptoms are with me 24 hours per day (never stopping)
If yes please circle all symptoms that are present 24 hours per day,

- **Off balance when standing or walking**
- **Off balance when sitting or lying**
- **Lightheaded or fainting sensation**
- **Tumbling or spinning sensation**

YES or **NO** My symptoms occur in spells
If yes please circle all symptoms that are present 24 hours per day,

- **Off balance when standing or walking**
- **Off balance when sitting or lying**
- **Lightheaded or fainting sensation**
- **Tumbling or spinning sensation**

Circle the one, that on average, describes the length of a typical, single spell,

- **Measured in seconds**
- **Measured in minutes to hours but less than 24 hours**
- **Measured in hours to days but less than 7 days**
- **Measured in days, can last continuously for weeks**

Circle the one, that on average, describes how frequently your spells are occurring,

- **Daily or multiple times per day**
- **Multiple times per week**
- **Multiple times per month**

YES or **NO** My symptoms occur when I am sitting, standing, lying completely still, NOT having just moved and NOT watching anything that is moving.
If yes circle all symptoms that occur with your movement and position changes,

- **Off balance**
- **Lightheaded or fainting sensation**
- **Tumbling or spinning sensation**

Are your symptoms made worse by any of the following? Circle all that apply

Lying down/ rolling in bed	Walking in the dark	Hot baths or shower
Menstrual cycle	Automobile rides	Sitting up/ standing up
Loud sounds	Coughing/ sneezing/ nose blowing	Escalators
Walking on uneven surface	Supermarket aisles/ malls/ tunnels	Reading
Overexertion	Turning your head when walking	Lifting things
Exercise	Restaurants or movie theaters	Windshield wipers

ASSOCIATED SYMPTOMS AND PROBLEMS
Circle all of the following symptoms that you have experienced,

- Unexplained falls? In past or with dizziness/ imbalance?
- Sensation of being pulled down? In past or with dizziness/ imbalance?
- Sensation of being pushed down? In past or with dizziness/ imbalance?
- Sensation of swaying or rocking? In past or with dizziness/ imbalance?
- Loss of consciousness (black out) In past or with dizziness/ imbalance?
- Nausea and/ or vomiting? In past or with dizziness/ imbalance?
- Double vision? In past or with dizziness/ imbalance?
- Vision “jumps” when walking/ riding? In past or with dizziness/ imbalance?
- Cloudiness or blurred vision? In past or with dizziness/ imbalance?
- Blindness In past or with dizziness/ imbalance?
- Heart racing/ palpitations In past or with dizziness/ imbalance?

- Panic feeling/ anxiety — In past or with dizziness/ imbalance?
- Numbness of face or extremities? — In past or with dizziness/ imbalance?
- Weakness or clumsiness? — In past or with dizziness/ imbalance?
- Difficulty with speech? — In past or with dizziness/ imbalance?
- Difficulty with swallowing? — In past or with dizziness/ imbalance?

VISION:

YES or **NO** I have experienced a temporary change in vision. Such as jagged lines, color spots or lightning bolts in your vision or loss of vision with recovery.

YES or **NO** Do you see spots before your eye?

YES or **NO** Have you had surgery to your eyes?
If yes, when and what type of surgery? _____

HEADACHES:

YES or **NO** I have been diagnosed with migraines. If yes, when? _____, and what medications are you taking?
_____

YES or **NO** I have had 5 or more headaches in my lifetime.

YES or **NO** I have had a headache that was severe enough to make me stop my activity and sit or lie down.

If you answered YES to any of the headache questions above, then please complete this next section, otherwise you can skip to the next.

YES or **NO** Headaches where the discomfort localizes to a region(s) of the head.
YES or **NO** Increased sensitivity to light during headache.
YES or **NO** Increased sensitivity to sound during a headache.
YES or **NO** A headache provoked by sudden bright light, such as sunlight.
YES or **NO** Certain foods or beverages increase the chances of a headache.
YES or **NO** Motion sickness as a young child prior to puberty.
YES or **NO** Nausea and/ or vomiting with a headache.
YES or **NO** Headache that lasts for more than 24 hours.
YES or **NO** Headaches associated w/ your problems of dizziness/ imbalance
YES or **NO** Headaches where the pain throbs or pulses.
YES or **NO** or **NA** Increased chance of headache around your menstrual cycle.
YES or **NO** or **NA** Change in headache behavior w/ pregnancy or after.

At what age do you remember having your first headache? _____

OTHER DISORDERS:

Do you currently have or have you been diagnosed in the past with any of the following?
Please circle if answer is yes.

Stroke	**Heart problems**	**Sexual dysfunction**	**Brain/spinal cord disorder**
Diabetes	**Cataracts**	**Joint disease**	**Anxiety/ depression/ panic**

Cancer **Loss of taste** **Loss of smell** **Ongoing breathing problem**

Glaucoma **Blood disease** **Memory Problems** **Ongoing stomach problems**

Significant weight changes **Ongoing numbness or tingling**

HOSPITALIZATIONS AND INJURIES:

Have you been in the hospital for any of the following or had any of the following injuries? Please circle all that apply.

Surgery on brain or spinal cord **Surgery on ear** **Eye injury**

Surgery on hips/knees/ankles Ear injury **Head or neck injury**

Broken back/hip/ knee/ankle

OTHER MEDICAL AND SOCIAL HISTORY:

Please indicate what tests you have completed for your problem?
Please circle all that apply.

Hearing test:	**normal**	**abnormal**	**I don't know**
MRI of brain with injection:	**normal**	**abnormal**	**I don't know**
MRI of brain without injection:	**normal**	**abnormal**	**I don't know**
MRI of the neck or back:	**normal**	**abnormal**	**I don't know**
VNG (water or air in the ear test):	**normal**	**abnormal**	**I don't know**
Electrocochleography (ECoG):	**normal**	**abnormal**	**I don't know**
EEG (brain wave test):	**normal**	**abnormal**	**I don't know**
Auditory Brainstem Test (ABR):	**normal**	**abnormal**	**I don't know**
Tilt table test (for fainting):	**normal**	**abnormal**	**I don't know**
Rotational chair for dizziness:	**normal**	**abnormal**	**I don't know**
Spinal tap (lumbar puncture):	**normal**	**abnormal**	**I don't know**
Posturography (standing balance):	**normal**	**abnormal**	**I don't know**
Doppler/Ultrasound blood flow:	**normal**	**abnormal**	**I don't know**
MRA of head/neck blood flow:	**normal**	**abnormal**	**I don't know**
Blood test for syphilis:	**normal**	**abnormal**	**I don't know**
Blood test for Lyme disease:	**normal**	**abnormal**	**I don't know**
Blood test for thyroid dysfunction:	**normal**	**abnormal**	**I don't know**
Blood test for CBC, electrolytes:	**normal**	**abnormal**	**I don't know**

_____

SOCIAL AND FAMILY HISTORY:

Please circle all that apply:

Smoke cigarettes **Toxic items** **Drink caffeinated beverages** **Recreational drugs** **Alcohol**

_____

FAMILY HISTORY:

Please circle all that apply:

Dizziness **Imbalance and/or falling** **Headaches** **Diabetes** **Heart disease**
Stroke **Hearing loss** **High blood pressure** **Anxiety**

_____

MEDICATIONS:

Please list (or attach a list) of all current prescriptions, over the counter medications, and the reason you are taking the medication. Also list medications you have tried in the past for your problem:

Current prescriptions and over the counter:

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

Medications used in the past you have taken for your current problem:

- _____
- _____
- _____

Thank you for your time. Please bring this questionnaire and all attached paperwork to your scheduled appointment.