8230 Walnut Hill Lane
Building 3, Suite 420
Dallas, Texas 75231
P: (214) 265-0800
F: (214) 265-1027

SouthWest ENT
ADULT & PEDIATRIC
EAR, NOSE & THROAT SPECIALISTS

6300 W. Parker Rd
Building 2, Suite 221
Plano, Texas 75093
P: (972) 378-3708
F: (972) 378-5385

Pre-Appointment Patient Dizziness Questionnaire

This questionnaire must be filled out before you schedule an appointment with our office. This questionnaire is to determine whether the dizziness you are experiencing can be treated by Dr. Evan Bates. Once we receive the questionnaire Dr. Bates will review it and our office will call to inform you of the results.

This questionnaire must be filled out in its entirety.

Date this form was completed: _____

Patient Name: _____ Date of Birth: _____

Phone Number: _____

Name of Referring Physician: _____

Referring Physician's Phone Number: _____

Is this appointment for the purpose of a disability claim or for a legal claim?
_____ Yes _____ No

Have you seen other health care providers for your problems of dizziness and/or imbalance?
_____ Yes _____ No
If yes, please indicate the specialty and name of persons you have seen: _____
_____

How would you describe your dizziness (check all that apply):
_____ Vertigo (an intense spinning sensations)
_____ Wooziness (feeling drunk-like)
_____ Imbalance (unable to maintain balance)
_____ Faint or lightheaded
_____ Swimming sensation inside your head
_____ Pulsion (being pulling in a direction)
_____ Other: _____

Have you been treated with medication for your dizziness and/or imbalance?
_____ Yes _____ No
If yes, please list what has been tried: _____

Have you been through a program of Vestibular and/or Balance Rehabilitation Therapy?
_____ Yes _____ No

Have you had surgery of any kind for your dizziness and/or imbalance?
_____ Yes _____ No
If yes, please describe (i.e.: mastoid surgery, tube placement, repair hole in ear drum): _____
_____

Have you had an injection of medicine in your ear for your dizziness and/or imbalance?
_____ Yes _____ No
If yes, please describe: _____

Main Problem

Briefly state the problem for which you are seeking help. Describe your symptoms.

_____
_____
_____
_____
_____

Was the onset of current problem: _____ Sudden _____ Gradual

When did your symptoms or similar symptoms FIRST begin (no matter how long ago)? _____

_____

Have your symptoms *changed* since they first began?

_____ Yes _____ No

If yes, in what way have they changed? _____

_____

Are your symptoms with you 24 hours per day – never stopping?

_____ Yes _____ No

If yes, check all symptoms that are present 24 hours per day – never stopping:

_____ Off balance when standing or walking
_____ Off balance when sitting or lying down
_____ Lightheaded or fainting sensation
_____ Tumbling or spinning sensation

Do you have symptoms that occur in spells?

_____ Yes _____ No

If yes, check all symptoms that occur in spells (no matter how long the spell):

_____ Off balance when standing or walking
_____ Off balance when sitting or lying down
_____ Lightheaded or fainting sensation
_____ Tumbling or spinning sensation

Check the one that (on the average) describes the length of a typical, single spell:

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

Check the one that (on the average) describe how frequently your spells are occurring:

_____ Daily or Multiple times per day
_____ Multiple times per week
_____ Multiple times per month
_____ Several times in a 2 month interval
_____ Several times in a 6 month interval
_____ Several times in a 12 month interval

Do you ever have symptoms occur when you are sitting, standing or lying completely still, NOT Having just moved and NOT watching anything that is moving?

_____ Yes _____ No

If yes, check all symptoms that occur in the spontaneous manner:

_____ Off balance
_____ Lightheaded or fainting sensation
_____ Tumbling or spinning sensation

Do you ever have symptoms that are provoked by your making a movement or change in position?

_____ Yes _____ No

If yes, check all symptoms that occur in the spontaneous manner:

_____ Off balance
_____ Lightheaded or fainting sensation
_____ Tumbling or spinning sensation

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

_____ Lying down/rolling in bed
_____ Walking in the dark
_____ Hot baths or showers
_____ Menstrual cycle
_____ Automobile rides
_____ Loud sounds
_____ Reading
_____ Exercise
_____ Stress or nerves
_____ Sitting up/Standing Up
_____ Walking on uneven surfaces
_____ Coughing/sneezing/nose blowing
_____ Supermarket aisles/malls/tunnels
_____ Windshield wipers
_____ Restaurants or movie theaters
_____ Turning your head when walking
_____ Reaching or bending

Is there anything else you know of that will provoke or make your dizziness worse? _____

_____

ASSOCIATED SYMPTOMS AND PROBLEMS

Check all the following symptoms that you have experienced:

Symptom	*in past only*	*with your current problem*
Unexplained falls If having falls, how often in the last 12 months?_____ Were you injured? _____Yes _____No	_____	_____
Sensation of being pulled or pushed down	_____	_____
Sensation of rocking or swaying	_____	_____
Loss of consciousness (blacked out)	_____	_____
Nausea and/or vomiting	_____	_____
Double vision (side by side or up down)	_____	_____
Does your vision "jump" when walking/riding	_____	_____
Heart racing	_____	_____
Panic feeling – a sudden need to leave a place	_____	_____
Chest pains	_____	_____

This section deals with headaches. It is important to complete as it is indicated.

1) Have you had a total of 5 or more headaches (does not matter how severe) in your lifetime?
   _____ Yes _____ No
2) Have you ever had a headache that severe enough to make you stop you active and sit or lie down?
   _____ Yes _____ No
3) Have you ever experienced a temporary change in your vision, such as jagged line, color spots or lightning bolts in your vision; loss of vision with recovery; etc.?
   _____ Yes _____ No
4) Have you ever been diagnosed with migraine headaches?
   _____ Yes _____ No

Please check any of the following that you have experienced:

_____ Headaches where the discomfort localizes a region(s) of the head
_____ Increased sensitivity to light during a headache
_____ Increased sensitivity to sound during a headache
_____ Increased sensitivity to odors during a headache
_____ A headache provoked by a sudden bright light, such as sun light
_____ Certain foods or beverages increase the chances of a headache
_____ Motion sickness as a young child prior to puberty
_____ Nausea and/or vomiting with a headache
_____ Headache that lasted longer than 24 hours
_____ Headaches associated with your problems of dizziness or imbalance
_____ Headaches where the pain throbs or pulses

If having headaches, at what age do you first remember having a headache?

_____ Under age 12
_____ In your teens
_____ In your twenties or thirties
_____ In your forties
_____ In your fifties
_____ In your sixties, seventies, or eighties

Have headaches been a significant problem in the past 6 months?

_____ Yes _____ No

If having headaches, what triggers your headache?_____
_____

HEARING SECTION

Check all of the following that apply to you:

_____ I think I have hearing loss, but this is not confirmed by testing
_____ I have documented hearing loss
If have hearing loss or think you do, is it…
_____ In both ears
If in both ears, which is worse? _____ Left _____ Right _____ Same
_____ Only the right ear
_____ Only the left ear
_____ My hearing changes from day to day
_____ I have ringing or noise that I hear
If you have a ringing or noise is it…
_____ In both ears
If in both ears, which is worse? _____ Left _____ Right _____ Same
_____ Only the right ear
_____ Only the left ear
_____ Present all the time
_____ I have a feeling of fullness or pressure in my ear(s)
If you have the feeling of fullness or pressure is it…
_____ In both ears
If in both ears, which is worse? _____ Left _____ Right _____ Same
_____ Only the right ear
_____ Only the left ear
_____ Present all the time
_____ I have pain in my ear(s)
If you have pain is it…
_____ In both ears
If in both ears, which is worse? _____ Left _____ Right _____ Same
_____ Only the right ear
_____ Only the left ear
_____ Present all the time
_____ I have frequent ear infections/drainage from my ear(s)
If you have frequent ear infections/drainage is it…
_____ In both ears
If in both ears, which is worse? _____ Left _____ Right _____ Same
_____ Only the right ear
_____ Only the left ear
_____ Present all the time

OTHER DISORDERS

Do you currently have or have you been diagnosed in the past with any of the following?
Please check all that apply.

_____ Stroke
_____ Heart problems
_____ Cancer
_____ Diabetes
_____ Cataracts
_____ Blood disease
_____ Sexual dysfunction
_____ Seizures
_____ Loss of taste
_____ Loss of smell
_____ Neck pain
_____ Brain or spinal cord disorder
_____ High blood pressure
_____ Anxiety/depression/panic
_____ Glaucoma
_____ Ongoing breathing problems
_____ Significant Weight Changes
_____ Memory Problems
_____ Ongoing numbness or tingling
_____ Ongoing stomach problems
_____ Joint disease
_____ Hip or knee replacement

HOSPITALIZATIONS AND INJURIES

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

_____ Treated for cancer with:
_____ radiation to the head or neck
_____ chemotherapy
_____ Hospitalized for treatment of an infection with IV antibiotic therapy
_____ Ear injury
_____ Surgery on brain or spinal cord

_____ Surgery on either eye
_____ Eye injury
_____ Head or neck injury
_____ Surgery on hips/knees/ankles
_____ Broken back/hip/knee/ankle

If you checked any of the above please briefly describe: _____
_____
_____

OTHER MEDICAL, SURGICAL, AND SOCIAL HISTORY

Please indicate what tests you have had for your problem. Check all that apply.

Test	Normal	Abnormal	Don't Known
Hearing Test (Audiogram)	_____	_____	_____
MRI of brain with injection	_____	_____	_____
MRI of brain without injection	_____	_____	_____
CT scan of head	_____	_____	_____
VNG/ENG (Electronystagmography – caloric or air in the ear test)	_____	_____	_____
Electrocochleography (ECoG)	_____	_____	_____
VEMP (clicks in ear and measure muscle response in neck)	_____	_____	_____
EEG (Electroencephalography Brain wave test)	_____	_____	_____
EKG (heart wave recording)	_____	_____	_____
Holter cardiac rhythm monitoring	_____	_____	_____
Auditory brainstem test (ABR/BAER)	_____	_____	_____
Tilt table test (for fainting)	_____	_____	_____
Rotational chair test for dizziness	_____	_____	_____
Spinal tap (Lumbar puncture)	_____	_____	_____
Posturography (standing balance test)	_____	_____	_____
Doppler/Ultrasound blood flow test	_____	_____	_____
MRA of head and neck blood flow	_____	_____	_____
Blood test for syphilis	_____	_____	_____
Blood test for Lyme disease	_____	_____	_____
Blood test for Thyroid function	_____	_____	_____
Blood test for HIV	_____	_____	_____
Blood test for CBC, electrolytes, etc.	_____	_____	_____

Do you have a pacemaker, cochlear implant or any other metal in your body that would prevent you from having an MRI?
_____ Yes _____ No
If yes, please explain: _____

Have you ever had any surgery on either ear?
_____ Yes _____ No
If yes, please explain: _____

SOCIAL AND FAMILY HISTORY
Please check all that apply to you.

_____ I smoke _____ Drink beverages with caffeine _____ Alcohol
_____ I have repeated directed exposure to loud noises _____ I live alone
_____ I have a history of use of 'recreational drugs'
_____ I have a history of occupational exposure to mercury, lead or toxic chemicals
_____ I have family members with the following:
_____ Dizziness _____ Imbalance and/or falling _____ Headaches
_____ Diabetes _____ Heart disease _____ Stroke
_____ Hearing loss _____ High blood pressure _____ Anxiety

Medication – Please attach or write below a **complete** list of: current prescription, over-the-counter drugs, or supplements you are taking (list ALL medications for all conditions).

_____
_____
_____
_____
_____
_____
_____

Please return this form together with any test results or doctor's notes you have related to your current problem. 0ÌÅÁÓÅ ÈÁÖÅ ÁÌÌ materials mailed to our office, the address is on the first page, or faxed to (214) 265-1027