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Ear Problems / Hearing Loss / Dizziness Questionnaire

Please fill out this as best as you can, and **CIRCLE** any that applies.

Patient Last Name _____ **First** _____ **DOB**_____ **Chart #**_____
Chief Complaint (list the ONE main problem)_____ **For how long?**_____

DIZZINESS/UNSTEADINESS

Date of onset _____
My dizziness includes: (Circle any that apply)
- A lightheaded feeling
- Spinning
- Unsteadiness
- Other_____

My dizziness/unsteadiness is:
- Mild
- Moderate
- Severe
- Severe with functional impairment (affects my daily activity)

Are you having the dizziness now? Y N
Duration
- Seconds
- Minutes
- Hours
- Days
- Constant

What brought it on (setting)? _____
_____
What makes it worse?
- Head position / movement
- Lying down / Standing up
- Light or sound
- Exercise, sneezing or coughing
- Other _____

What makes it better? _____
_____
Do you have any of these associated symptoms?
- Headache (before or after) / Migraines?
- Fall with injury caused by the dizziness
- Loss of consciousness / Passing out
- Nausea / Vomiting
- Seeing lights / face numbness or tingling
- Jaw pain, jaw popping, TMJ problems

Does anyone in your family have Migraines? Y N

EAR SYMPTOMS

Ear pain…… (Right / Left)
Ear drainage…… (Right / Left)
Pressure/fullness in the ear……. (Right / Left)
Hearing loss…….. (Right / Left)
Date of onset _____
Sudden hearing loss……. (Right / Left)
Progression of hearing loss……. (Right / Left)
Ringing/buzzing/head noise…… (Right / Left)
Fluctuating hearing/ringing/fullness.. (Right / Left)
Hearing Aids(How long _____ (Right / Left)
Do they help? Y N
Which ear is your better ear? ….. (Right / Left)

Did you have infections as a child? Y N
Did you require ear tubes? Y N # _____
Do you have infections as an adult? Y N
How often? _____

Have you had previous testing? Y N
Hearing Test - Date:_____
Location:_____
Balance Test - Date:_____
Location:_____
CT Scan - Date:_____
Location:_____
MRI - Date:_____
Location:_____
Other - Date:_____
Location:_____

What, if any, diagnosis have you been given? ___
_____
_____

What, if any, treatment have you received? ____
_____
_____
_____

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