

ASSOCIATED NEUROLOGICAL SPECIALTIES

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Dizzy Questionnaire- Long

This questionnaire will become a permanent part of the patient's medical record:

Name: _____ Age: _____ Today's Date: _____

Are you right-handed? _____ OR left-handed _____ ?

Present Occupation: _____

Prior Occupations: _____

Education (Highest Level): _____

(Subject): _____

Name and Addresses of physician(s) or attorney(s) you wish our reports sent:

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY. PLEASE GIVE NECESSARY DETAILS FOR YES ANSWERS. There is additional room at the end of each section and the end of the questionnaire for comments. We realize this form is long, but when it is filled out carefully, it allows us to devote more time to your specific problem, rather than asking you unrelated questions during your visit.

1. Describe your major problem and the reason why you are seeing us:

5. Please mark each symptom and give DETAILS for all "Yes" answers:

YES

NO

- | | | |
|-----|-----|---|
| ___ | ___ | Trouble with walking? |
| ___ | ___ | Trouble with balance? |
| ___ | ___ | Any falls? |
| ___ | ___ | Difficulty turning over in bed? |
| ___ | ___ | Sense of motion in the environment? |
| ___ | ___ | Sense of motion in one's own body? |
| ___ | ___ | Sensation of one's body tilting? (Which way?) |
| ___ | ___ | Sensation of one's body pulling? (Which way?) |
| ___ | ___ | Sensation of Rotation or spinning? (Which way?) |
| ___ | ___ | Sense of rocking? |
| ___ | ___ | Spinning inside of one's head? |
| ___ | ___ | Sense of walking on pillows? |
| ___ | ___ | Lightheadedness or faintness? |
| ___ | ___ | Fear of avoidance of public places? |
| ___ | ___ | Sweating? |
| ___ | ___ | Nausea? |
| ___ | ___ | Vomiting? |
| ___ | ___ | Impaired Vision? |
| ___ | ___ | -Double Vision? |
| ___ | ___ | -Images separated side-to-side, up and down, or tilted? |
| ___ | ___ | -Blurred vision? |
| ___ | ___ | -Flashes of light? |
| ___ | ___ | -Jumping of vision? |
| ___ | ___ | -Trouble Reading? |
| ___ | ___ | Dry eyes? |
| ___ | ___ | Dry mouth? |
| ___ | ___ | Trouble with taste? |
| ___ | ___ | Trouble with smell? |

6. What do you think your problem is due to?

7. What have you been told your problem is due to?

8. TO WHAT EXTENT IS YOUR DIZZINESS OR IMBALANCE AFFECTED OR BROUGHT ON BY:

SEVERELY

MODERATELY

NOT AT ALL

_____	_____	_____	Turning over in bed?
_____	_____	_____	Bending over, looking up?
_____	_____	_____	Standing up quickly?
_____	_____	_____	Rapid head movements?
_____	_____	_____	Walking in the dark?
_____	_____	_____	Elevators, escalators, or stairs?
_____	_____	_____	Airplane, boat, or car travel?
_____	_____	_____	Scuba diving?
_____	_____	_____	Loud noises?
_____	_____	_____	Cough, sneeze, strain, or laugh
_____	_____	_____	Moving Objects (eg. Computer screens, lights, windshield wipers, TV or movies)?
_____	_____	_____	Moving your eyes with your head still?
_____	_____	_____	Are you dizzy with your eyes closed?
_____	_____	_____	Touching your ears?
_____	_____	_____	Wide-open or narrow spaces (eg. Shopping malls, supermarket)?
_____	_____	_____	Tunnels, bridges, or heights
_____	_____	_____	Thinking about or anticipating going to a specific place
_____	_____	_____	Exercise (Aerobics, jogging)
_____	_____	_____	Other activities? (What)?
_____	_____	_____	Eating or missing meals?
_____	_____	_____	Special foods (salt, MSG, cheese, wine, chocolate, alcohol, caffeine)?
_____	_____	_____	Heat, hot showers or baths, or cold?
_____	_____	_____	Time of day?
_____	_____	_____	Swallowing?
_____	_____	_____	Depression, anxiety, nerves, or stress
_____	_____	_____	Menstrual periods?

DETAILS:

9. Other questions concerning dizziness:

YES

NO

- ___ ___ Can you bring on your dizziness voluntarily?
(IF YES, PLEASE GIVE DETAILS)
- ___ ___ Do or did you have moderate to severe motion sickness?
(CAR OR BOAT, PLEASE DESCRIBE)
- ___ ___ Do you ice skate; do gymnastics, or high intensity aerobics?
- ___ ___ Has anyone observed jerking of your eyes with dizzy spells?
- ___ ___ Have you had a caloric (air or water in the ear) test?
- ___ ___ Was the sensation induced similar to your own dizziness?
- ___ ___ Does your dizziness resemble the sensation provoked by spinning oneself round and round and then stopping?

10. HAVE YOU EVER HAD: (IF YES, PLEASE GIVE DETAILS)

YES

NO

- ___ ___ Infections of the ears?
- ___ ___ Sinus disease?
- ___ ___ Inner ear disease (eg. LABYRINTHITIS)?
- ___ ___ Difficulty with hearing? (WHICH EAR?)
- ___ ___ Pain, fullness, popping, or pressure in the ear? (WHICH EAR?)
- ___ ___ Ringing in the ears? (TINNITUS)
Which ear? _____ Steady or pulsating? _____
High or low pitched?
State the frequency and duration of the tinnitus:
- ___ ___ Pain, pins & needles, numbness, twitching, or weakness of face?
- ___ ___ Crossed eyes or lazy eye?
- ___ ___ Do you wear glasses? (FOR READING, FAR VIEWING, OR BOTH)
- ___ ___ Are you very nearsighted?

11. Have you had migraine or other headaches?

A. If yes, please answer the following:

Approximate age they began: _____

Frequency of headaches in last 6 months:

Pain intensity (1 to 10, with 10 the most severe): _____

B. If yes, does your headache usually:

YES NO

- ___ ___ Last 4 hours or more
- ___ ___ Start on one side of the head? Which side? _____
- ___ ___ Throbbing or pulsatile in quality?
- ___ ___ Severe enough to interfere with your schedule?
- ___ ___ Related to diet or menstrual periods?
- ___ ___ Aggravated by routine physical exercise?
- ___ ___ Made worse by climbing stairs?
- ___ ___ Brought on by cough, sneeze, or strain?
- ___ ___ Associated with nausea and/or vomiting?
- ___ ___ Aggravated by bright lights or loud noises?
- ___ ___ Preceded by bright or flashing lights or zigzag lines?
- ___ ___ Usually relieved by dark rooms and/ or sleep?
- ___ ___ Require medications? (Which medications and how often?)
-
- ___ ___ **Do you take medication more than 2 times per week?**

12. CIRCLE AND GIVE DETAILS OF SYMPTOMS YOU HAVE HAD IN THE LAST FEW YEARS:

- Weight change (Gain or loss, how much, & over what period)
- Strength or Energy Change
- Memory Loss (Amnesia)
- Skin Rash or Birthmarks
- Numbness in Arms or Legs
- Loss of Bowel Control
- Loss of Bladder Control
- Problems with Sexual Function
- Excessive Daytime Sleepiness or Naps
- Trouble Chewing, Swallowing
- Snoring or Sleep Apnea
- Appetite Change
- Change in Handwriting
- Sore in Mouth or Genitals
- Lump in Throat
- Fever or Chills
- Problems with Sleeping
- Abnormal Menstrual Periods
- Sweating
- Tremor or Shakiness
- Muscle Aches
- Joint Aches
- Diarrhea
- Heart Palpitations
- Swollen Glands
- Incoordination
- Shortness of Breath
- Change in Speech
- Stiffness

13. HAVE HAD ANY INJURIES? (IF YES, PLEASE EXPLAIN)

YES

NO

- | | | |
|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Ears? |
| <input type="checkbox"/> | <input type="checkbox"/> | Eyes? |
| <input type="checkbox"/> | <input type="checkbox"/> | Retinal Detachment? |
| <input type="checkbox"/> | <input type="checkbox"/> | Head? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you seen a Chiropractor? When? |
| <input type="checkbox"/> | <input type="checkbox"/> | Miscarriages? |
| <input type="checkbox"/> | <input type="checkbox"/> | Other Injuries? |

14. HAVE YOU HAD ANY SURGERY? (IF YES, DESCRIBE THE SURGERY AND WHEN IT OCCURRED)

YES

NO

- | | | |
|--------------------------|--------------------------|--------|
| <input type="checkbox"/> | <input type="checkbox"/> | Ears? |
| <input type="checkbox"/> | <input type="checkbox"/> | Eyes? |
| <input type="checkbox"/> | <input type="checkbox"/> | Head? |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck? |
| <input type="checkbox"/> | <input type="checkbox"/> | Other? |

15. HAVE YOU BEEN EXPOSED TO OR EXPERIENCED ANY OF THE FOLLOWING? (IF YES, PLEASE DESCRIBE THE EXPOSURE AND WHEN IT OCCURRED).

YES

NO

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Poisons, gases, chemicals, or carbon monoxide? |
| <input type="checkbox"/> | <input type="checkbox"/> | Tropical Diseases? |
| <input type="checkbox"/> | <input type="checkbox"/> | Tick Bites? |
| <input type="checkbox"/> | <input type="checkbox"/> | Intravenous Antibiotics? |
| <input type="checkbox"/> | <input type="checkbox"/> | Military Service overseas? (Where?) |
| <input type="checkbox"/> | <input type="checkbox"/> | Travel to central or South America, Asia, Africa? |
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS? |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood Transfusions? |
| <input type="checkbox"/> | <input type="checkbox"/> | Loud Noise? (eg. Guns, Machinery, Loud Music?) |
| <input type="checkbox"/> | <input type="checkbox"/> | Drug Therapy for cancer? (eg. Chemotherapy) (What type?) |
| <input type="checkbox"/> | <input type="checkbox"/> | Medication for depression, anxiety, or other psychiatric disease? (Lithium, Valium, Dilantin, Tegretol, sleeping pills, Ativan, Xanax, Phenothiazine, OR any other tranquilizers?) (what type and when?) |

16. HAVE YOU HAD ANY OF THE FOLLOWING INFECTIONS? (IF YES, PLEASE GIVE DETAILS)

- | <u>YES</u> | <u>NO</u> | |
|------------|-----------|---|
| ___ | ___ | Syphilis or other sexually transmitted disease? |
| ___ | ___ | Mononucleosis (Epstein-Barr)? |
| ___ | ___ | Lyme Disease? |
| ___ | ___ | Meningitis? |
| ___ | ___ | Other Infections? |

17. HAS YOUR PAST OR PRESENT HEALTH BEEN AFFECTED BY:

- | <u>YES</u> | <u>NO</u> | |
|------------|-----------|---|
| ___ | ___ | Heart Problems? |
| ___ | ___ | Diabetes? |
| ___ | ___ | Low sugar (hypoglycemia)? |
| ___ | ___ | Thyroid Disorders? |
| ___ | ___ | Treatment by a psychiatrist or counselor? |
| ___ | ___ | Depression; thought of harming yourself; feeling of worthlessness; crying spells? |
| ___ | ___ | Stress? |
| ___ | ___ | Eating disorders or phobias? |
| ___ | ___ | Anxiety or panic attacks? |
| ___ | ___ | High cholesterol (triglycerides)? |
| ___ | ___ | High or low blood pressure? |
| ___ | ___ | Pain in back of jaw (TMJ), grinding? |
| ___ | ___ | Loss of consciousness (fainting), seizures, or convulsions? |
| ___ | ___ | Blood diseases, anemia? |
| ___ | ___ | Skin diseases? |

18. List all major illnesses, injuries, surgeries, or miscarriages not described above.

19. What are your current medications? (Include all medications, hormones, birth control pills, over-the-counter medications, vitamins, herbal medications, and other alternative therapies and AMOUNT/ DAY:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

20. What other medications have you taken for your dizziness? (Include dosage, for how long, and effectiveness):

_____	_____
_____	_____
_____	_____

21. List all known allergies, including those to medications or bad reactions to medicines.

22. Social History:

YES

NO

___ ___ Do or did you use alcohol? How much? How does alcohol affect your condition?

___ ___ Do or did you ever smoke? If so, please answer the following:

a. How many packs/ day? _____

b. What age did you start? _____

c. If you quit, at what age? _____

___ ___ Do or did you ever use drugs?

LSD?___ Cocaine?___ Crack? ___ Marijuana? ___ Other?_____

___ ___ Do you use salt to eat salty foods?

___ ___ Do you have an unusual diet? Vegetarian?

___ ___ Do you have pets? If so, what kind and how many?

___ ___ What are your hobbies?

23. Personality

a. Would you describe yourself as any of the following:

- | | | |
|-------------------|------------------|--------------------|
| Obsessive | Manic | Compulsive |
| Down or Depressed | Prone to Anxiety | Melancholy or Blue |
| Hypochondriac | Phobic | |

b. Do you set your watch ahead?_____ How much?_____

24. Family History

a. Do you have children? _____ If so, what are their ages? Their health condition?

b. Do you have brothers or sisters? _____ If so, what are their ages? Their health conditions?

c. Do you have any family members with the following (Please indicate which family member; include also grandparents, aunts, uncles, nieces, nephews, and cousins):

<u>YES</u>	<u>NO</u>	
___	___	The same condition as you have?
___	___	Migraine Headaches?
___	___	Meniere's Syndrome?
___	___	Hearing Loss?
___	___	Vertigo or Dizziness?
___	___	Balance Problems?
___	___	Tremor?
___	___	Convulsions or seizures?
___	___	Diabetes?
___	___	Cancer?
___	___	Kidney Problems?
___	___	Brain Tumors?
___	___	Stroke?
___	___	Heart Disease?
___	___	High Blood Pressure?
___	___	Psychiatric Disorders, Depression, or Panic Attacks?
___	___	Memory Problems, Dementia, or Alzheimer's?
___	___	Other Neurological Diseases?
___	___	Any other conditions that run in the family?
___	___	Mental Retardation?

d. If your parents, brothers, sisters, or any children have died, at what age and from what cause?

25. Have you had the following:

<u>YES</u>	<u>NO</u>		<u>WHO/ RESULT</u>	<u>WHEN</u>
___	___	Hearing Test?		
___	___	Evaluation by another neurologist?		
___	___	Evaluation by an ear doctor?		
___	___	Caloric Test? (Water or air in ear)		
___	___	MRI?		
		(If so, was contrast given by injection?)		
___	___	Brain Arteriogram?		
___	___	Carotid Artery Blood Flow Supply?		
___	___	BAER? (Auditory Evoked Potentials)		
___	___	VER? (Visual Evoked Potentials)		
___	___	Sinus X-rays?		
___	___	Neck X-rays?		
___	___	MRI of Neck or Spine?		
___	___	CT Scan of head, neck, or spine?		
___	___	Spinal Fluid Examination?		
___	___	EEG (Brain Wave Study)?		
___	___	EMG/ Nerve Conduction Study?		

26. Have you recently had the following:

<u>YES</u>	<u>NO</u>		<u>WHO/ RESULT</u>	<u>WHEN</u>
___	___	Blood Work?		
___	___	Urinalysis?		
___	___	Chest X-Ray?		
___	___	Mamograms?		
___	___	GYN (Pelvic) exam?		
___	___	Echocardiogram?		
___	___	ENG?		
___	___	Lyme Test?		
___	___	Glucose Tolerance Test?		
___	___	B12 Test?		
___	___	Thyroid test?		
___	___	AIDS test?		

27. Handwriting specimen: Please write the following: "Whether or not you leave here early does not matter."

28. Additional Comments: