EAR SPECIALISTS
MEDICAL QUESTIONNAIRE

Name_____ Age_____ Sex_____ Date _____

Who requested this consultation?_____ Family Physician _____

Please complete the following as accurately as possible and if applicable.

Reason for your visit today: _____

The following refers to dizziness:

Do you ever have any of the following sensations?

Sense of spinning or motion	Yes ☐	No ☐
Falling to one side	Yes ☐	No ☐
World spinning around you	Yes ☐	No ☐

Referring to a typical dizzy spell:

Do they come in attacks?	Yes ☐	No ☐
Does anything bring on an attack?	Yes ☐	No ☐
How often? _____		
Duration? _____		
Date of first spell _____		
Are you free of dizziness between attacks?	Yes ☐	No ☐
Does your hearing change with an attack?	Yes ☐	No ☐
Do your ears "ring" with an attack?	Yes ☐	No ☐
Fullness or pressure in the ears?	Yes ☐	No ☐
Does movement aggravate an attack?	Yes ☐	No ☐
Which position? _____		
Do you become nauseated during an attack?	Yes ☐	No ☐
Does lying down or rolling over in bed bring on dizziness?	Yes ☐	No ☐
Was there a preceding cold or flu before the attack?	Yes ☐	No ☐

Referring to other sensations you may have:

Do you black out or faint when you are dizzy?	Yes ☐	No ☐
Do you have severe or recurrent headaches?	Yes ☐	No ☐
Double vision?	Yes ☐	No ☐
Numbness in your face or extremities?	Yes ☐	No ☐
Weakness or clumsiness in arms, hands, legs?	Yes ☐	No ☐
Slurred or difficult speech?	Yes ☐	No ☐
Difficulty swallowing?	Yes ☐	No ☐
Tingling around your mouth?	Yes ☐	No ☐
History of skull fracture or concussion?	Yes ☐	No ☐
Dizziness with standing or sitting up quickly?	Yes ☐	No ☐
Weakness or dizziness after eating?	Yes ☐	No ☐

The following refers to your hearing and ears:

Difficulty hearing?
Right ☐ Left ☐ Both ☐ How long? _____

"Ringing" or noise in the ear?
Right ☐ Left ☐ Both ☐ How long? _____

Fullness or pressure in the ear?
Right ☐ Left ☐ Both ☐ How long? _____

Drainage from the ear?
Right ☐ Left ☐ Both ☐

Pain in the ear?
Right ☐ Left ☐ Both ☐

Exposure to loud noise?	Yes ☐	No ☐
By what? _____		
Previous ear surgery?	Yes ☐	No ☐
What _____		
When _____		

Family history of hearing loss and whom? _____

_____

The following refers to habits and life-style:

Do you smoke?	Yes ☐	No ☐
How much? _____		
Do you drink alcohol?	Yes ☐	No ☐
How much? _____		
Do you drink coffee?	Yes ☐	No ☐
How much? _____		
Do you drink tea?	Yes ☐	No ☐
How much? _____		
Do you drink soft drinks?	Yes ☐	No ☐
How much? _____		
Do you eat salty foods or add salt?	Yes ☐	No ☐
Do you wear hearing aids?	Yes ☐	No ☐
Substance abuse & use	Yes ☐	No ☐
Do you have a living will regarding advance medical directives?	Yes ☐	No ☐
Do you want information?	Yes ☐	No ☐

Medical History (high blood pressure, diabetes, etc.)

_____

_____

Surgery History (List all previous surgical procedures and approximate dates)

_____

_____

List all medications you currently take (including over the counter medications)

_____

_____

List allergies to any medications: _____

What studies have been done previously? (Hearing or balance tests, blood tests, head scans, etc.)

_____

Other comments:

_____

_____