HearBright, an Audiology Corporation

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VNG QUESTIONNAIRE

Patient Name: ____________________ DOB: ____________ Sex: M / F Date: ____________

The following questions refer to your feeling of dizziness. Please answer them as "yes" or "no" and fill in all the blanks.

Please describe in your own words, the sensation you feel without using the word "dizzy" :

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Do you ever have any of the following sensations:

Yes No Spinning in circles
Yes No Falling to one side
Yes No World spinning around you

The following refer to a typical dizzy spell:

Yes No Was the attack sudden?
Date of first spell: ______________________________
Yes No Do the dizzy spells come in attacks?
How often is each attack? ________________________
How long is each attack? ________________________

Yes No In between attacks, are you functioning normal?
Yes No Do you feel a residual imbalance after attacks)?
Yes No Does your hearing change with an attack?
Yes No Are you mainly dizzy when you sit up or stand quickly?
Yes No Are you dizzy in a certain positions?
if so, what positions?: ______________________________
Yes No Are you nauseated during or after an attack?
Yes No Are you dizzy even when lying down?
Yes No Have you had a recent cold or flu proceeding recent dizzy spell?
Yes No Have you had fullness, pressure or ringing in your ears?
Yes No have you had pain or discharge from your ears of recent onset?
Yes No Have you had trouble walking in the dark?
Yes No Are you better if you sit or lie perfectly still?

The following refer to other sensations you may have:

Yes No Do you black out or faint when dizzy?
Have you had :

Yes No Severe or recurrent headaches?
Yes No Any double or blurry vision?
Yes No Numbness in your face or extremities?
Yes No Slurred speech or difficult speech?
Yes No Difficulty swallowing?
Yes No Tingling around your mouth?
Yes No Spots before your eyes?
Yes No Jerking of arms or legs?
Yes No Seizures?
Yes No Confusion or Memory loss?
Yes No Recent head trauma (if yes, please explain:)

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Past/Current Medical History:

Please list your current and past medical problems and length of illness:

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Please list **ALL** medicines you have taken **within the last 48 hrs** (including pain medicine, nonprescription medicine, sleeping pills, narcotics, barbituates, vertigo medication, tranquilizers, diuretics, anti-hypersensitive medications or birth control pills)

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Have you had any alcohol **within the last 48 hrs**? Yes No

Please list any diseases that run in your immediate family:

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***The following section refers to your hearing. **SKIP THIS SECTION** if you are a Returning patient.
NEW patients, proceed with answering the following questions:

Yes	No	Difficulty hearing in one ear?	Left	Right	Both
Yes	No	Ringing in one ear?	Left	Right	Both
Yes	No	Fullness in ears? Which ear?	Left	Right	Both
Yes	No	Change in hearing when dizzy?		How?	___

Have you had the following:

Yes	No	Eye surgery? Which eye?	Left	Right	Both
Yes	No	Pain in ears?	Left	Right	Both
Yes	No	Discharge from ears?	Left	Right	Both
Yes	No	Hearing change?	Left	Right	Both
Yes	No	Better?	Left	Right	Both
Yes	No	Worse?	Left	Right	Both
Yes	No	Exposure to loud noises?	Left	Right	Both
Yes	No	Previous ear infections?	Left	Right	Both
Yes	No	Previous ear surgery?	Left	Right	Both

If yes, when did the surgery take place? ___

What type of surgery? ___

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Yes No Family history of deafness or hearing loss?

Do you have anything else to tell us about your particular problem which we have not asked you on this questionnaire?

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YOU HAVE COMPLETED THE QUESTIONNAIRE, PLEASE HAND TO FRONT OFFICE STAFF