Robert M. Cain, MD

Phone (512) 992-2465
Fax (512) 454-2291

neurologyaustin@juno.com www.ansaustin.com

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:

BE VERY THOROUGH, HONEST AND COMPLETE IN YOUR ANSWERS

Patient Name:_____

2. Please describe in detail when and the circumstances in which the problem began and what were the initial symptoms and problems. What might have caused the problem to begin? Unusual exercise? Accident? Infection? Change in glasses? Change in type or dose of medications? Stress?

3. If you have dizzy spells, please describe a typical spell in as much DETAIL as possible and also describe the TRIGGERS, TIME OF OCCURRENCE, FREQUENCY, AND DURATION of the spells:

4. To what extent has your problem or spells changed since it first started? (For example: Severity, frequency, and characteristic)?

Patient Name:_____

5. Please nark 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?

BE VERY THOROUGH, HONEST AND COMPLETE IN YOUR ANSWERS

____ ____ 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?

Patient Name:_____

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)?

BE VERY THOROUGH, HONEST AND COMPLETE IN YOUR ANSWERS

_____ _____ _____ 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:

Patient Name:_____

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?

BE VERY THOROUGH, HONEST AND COMPLETE IN YOUR ANSWERS

____ ___ 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? (TINNUTIS)
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 -Appetite Change -Muscle Aches

BE VERY THOROUGH, HONEST AND COMPLETE IN YOUR ANSWERS

-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
-Change in Handwriting
-Sore in Mouth or Genitals
-Lump in Throat
-Fever or Chills
-Problems with Sleeping
-Abnormal Menstrual Periods
-Sweating
-Tremor or Shakiness
-Joint Aches
-Diarrhea
-Heart Palpitations
-Swollen Glands
-Incoordination
-Shortness of Breath
-Change in Speech
-Stiffness

Patient Name:_____

Patient Name:_____

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

YES	NO	
____	___	Ears?
____	___	Eyes?
____	___	Retinal Detachment?
____	___	Head?
____	___	Have you seen a Chiropractor? When?
____	___	Miscarriages?
____	___	Other Injuries?

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

YES	NO	
____	___	Ears?
____	___	Eyes?
____	___	Head?
____	___	Neck?
____	___	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	
____	___	Poisons, gases, chemicals, or carbon monoxide?
____	___	Tropical Diseases?
____	___	Tick Bites?
____	___	Intravenous Antibiotics?
____	___	Military Service overseas? (Where?)
____	___	Travel to central or South America, Asia, Africa?
____	___	AIDS?
____	___	Blood Transfusions?
____	___	Loud Noise? (eg. Guns, Machinery, Loud Music?)

BE VERY THOROUGH, HONEST AND COMPLETE IN YOUR ANSWERS

____ ___ Drug Therapy for cancer? (eg. Chemotherapy) (What type?)
____ ___ 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)

YES NO

____ ___ Syphilis or other sexually transmitted disease?
____ ___ Mononucleosis (Epstein-Barr)?
____ ___ Lyme Disease?
____ ___ Meningitis?
____ ___ Other Infections?

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

YES NO

____ ___ 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.

Patient Name:_____

Patient Name:_____

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:

_____
_____

BE VERY THOROUGH, HONEST AND COMPLETE IN YOUR ANSWERS

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

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?

Patient Name:_____

____ ___ 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

BE VERY THOROUGH, HONEST AND COMPLETE IN YOUR ANSWERS

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):

YES	NO	
____	___	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?

Patient Name:_____

____	___	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:

YES	NO		WHO/ RESULT	WHEN
____	___	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 Arteriorgram?		
____	___	Carotid Artery Blood Flow Supply?		

BE VERY THOROUGH, HONEST AND COMPLETE IN YOUR ANSWERS

____ ___ 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:

YES	NO		WHO/ RESULT	WHEN
____	___	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:

Patient Name:_____

BE VERY THOROUGH, HONEST AND COMPLETE IN YOUR ANSWERS