Roberts Hearing Clinic & Dizziness Diagnostic Center
4007 Parliament Dr, Alexandria, La 71303
318-442-9812

DIZZINESS QUESTIONNAIRE

Which of the following best describe your symptoms? (circle) all that apply:

light headedness *vertigo(spinning sensation)* *balance difficulties*

1. Do you get dizzy just turning over in bed? YES NO
   a. which direction are you laying when the dizziness occurs ?
   b. how long does the dizziness last?
   c. do you have a sense of spinning?
   d. does the dizziness cause nausea or vomiting?
   e. when did your first attack happen?
   f. how often have they occurred?
   g. do you have any warning before it occurs?
2. Are you light sensitive during your dizzy spell? YES NO
   describe: _____
3. Does one ear feel full before or during your attacks? YES NO
   describe: _____
4. Does a loud sound make you dizzy or make your world jiggle? YES NO
   describe:
   _____
5. Is your dizziness constant_____ or in attacks _____
6. Was you first attack, sever vertigo lasting hours with nausea and vomiting? YES NO
   describe:
   _____
7. Do you have lightheadedness when you get up from bed or a chair for a few seconds? YES NO
   describe: _____
8. Do you pass out completely with your dizziness? YES NO

9. Do you have to support yourself when walking in dark? YES NO

10. When you're dizzy, must you support yourself when standing? YES NO

11. Have you ever had a head injury? YES NO
    If you answered yes, were you unconscious? YES NO

12. Do you or have you ever had the following?
    a. Difficulty hearing? YES NO
       Which ear? RIGHT LEFT
    b. When did it start?_____
    c. Is it getting worse? _____
    d. Do you have noises in your ears? YES NO
       Which ear? BOTH RIGHT LEFT
    e. Does the noise change with the dizziness? YES NO

13. How would you rate your general health? GOOD FAIR POOR
    If fair or poor is marked, please explain:
    _____
    _____

14. Do you have a history of: Please check all that apply
    a. high blood pressure _____
    b. cancer _____
    c. Neurological diseases or disorders _____
    d. Psychological disorders _____
    e. Endocrine(thyroid disease) _____
    f. Eye disease or disorders _____
    g. Ear disease or disorders _____
    h. Migraines _____
    i. Other: _____

15. Have you ever had ear surgery? YES NO

16. Have you ever had an MRI? YES NO

17. Please list any medications you are presently taking:
    _____
    _____
    _____

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INFORMED CONSENT TO TREATMENT, OPERATION OR DIAGNOSTIC PROCEDURE

I, _____ authorize Roberts Hearing Clinic with associates or assistants of their choice, to perform the following diagnostic procedure Videonystagmograph (VNG),
testing the vestibulo-oculomotor reflex ARC with visual testing and irrigation of the ears with water calorics and a goggle system attached to the patients head, and any further action necessitated by an emergency medical situation.

A physician had adequately explained to me the nature, purpose, and effect of the above described diagnostic procedure, and the alternatives, the possibility of risks and complications, as well as, the chances of success. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of the procedure.

Further, I do hereby release and hold harmless Roberts Hearing Clinic and all persons assigned to my care from any and all responsibility and liability in connection with this procedure for personal items (dentures, jewelry, etc.) which I may keep on or about my person while with Roberts Hearing Clinic.

Witness:_____ Signed:_____
patient or person authorized by patient

Date:_____