Otoneurology clinic intake form

NAME	
BIRTHDATE	
AGE	
TODAY'S DATE	

DOCTOR TO WHOM WE SHOULD SEND REPORT:

HOME PHONE	
CELL PHONE	
WORK PHONE	
YOUR FAX	
YOUR EMAIL	
PHARMACY PHONE	

YOUR HOME MAILING ADDRESS:

Sex: ☐ M, ☐ F. Marital status: ☐ Single, ☐ Married, ☐ Widowed, ☐ Separated, ☐ Divorced

Patient employed by: _____

Business address: Street: _____ City: _____ State: _____ Zip: _____

Primary insurance: _____ Card holder name: _____

Secondary insurance: _____ Card holder name: _____

Please sign below to indicate that:

1. We have permission of the patient (or patient's surrogate) to ask the patient's other doctors for records related to the reason for this appointment.
2. The patient (or patient's surrogate) authorizes the release of any information needed by the insurance carrier to process the claim. The patient (or patient's surrogate) understands that the patient is financially responsible for all charges; these may include, but are not limited to, deductibles, co-pays, and "non-covered services."
3. The patient (or patient's surrogate) understands that unless mandated by state or federal law, Chicago Dizziness and Hearing does not do paperwork related to worker's compensation, disability, functional capacity evaluations, etc., nor do we respond to attorney queries.
4. We offered to the patient (or to the patient's surrogate), and the patient (or surrogate) has read and understood, the following documents (all of which are available at http://dizzy-doc.com/forms.php, and are also available on paper in our office):
    a. Information regarding diagnostic ear procedures, observation/recording of eye movements, and therapeutic procedures.
    b. Our Privacy Policy statement.
    c. Our Office and Financial Policies statement

_____ _____
(Signature of patient) (Date and time)

OR (*if patient is not capable of making informed decisions*):

_____ _____
(Signature of person authorized to consent for incompetent patient) (Date and time)

_____
(Relationship to patient)

Please note that Chicago Dizziness and Hearing does not do paperwork related to worker's compensation, disability, functional capacity evaluations, etc., nor do we respond to attorney queries.

Patient name: _____

Patient date of birth: _____

Questionnaire

Please complete this form carefully. We realize that it requires substantial effort, but it will enable us to spend more time examining you, and will help us in your diagnosis and treatment.

I found out about Chicago Dizziness and Hearing from:
☐ The internet.
☐ A friend or colleague.
☐ Doctor _____ referred me.
☐ Other: _____.

I am _____ years old.
I am ☐ right-handed, ☐ left-handed.
I am ☐ male, ☐ female.
The date that I am filling out this questionnaire is _____ .
(date)

Purpose of visit (please check all that apply)

☐ I am here for diagnosis and treatment.
☐ I am here for a second opinion.
☐ I am here for medico-legal reasons: a worker's compensation case.
☐ I am here for medico-legal reasons: an independent medical examination (IME).
☐ Other: _____

Present illness. I am here *primarily* because of (check all that apply):

☐ Dizziness, imbalance, lightheadedness, or other forms of disequilibrium.
☐ Hearing problem (such as hearing loss, excessively sensitive hearing, sound distortion)
☐ Abnormal sounds in the ear (also called "tinnitus")
☐ Other ear problems (such as ear fullness, ear wax, blood or other fluid coming out of the ear)
☐ Headache
☐ Other: _____.

Dizziness and balance symptoms. If you do not have dizziness or balance symptoms, please skip to the next section.

• My **symptoms** of disequilibrium include (check all that apply):

☐ Spinning, ☐ tumbling, ☐ cart-wheeling, ☐ tilting, ☐ rocking.
☐ Lightheadedness.
☐ Nausea, ☐ vomiting.
☐ Double vision, ☐ blurred vision, ☐ jumpy vision.
☐ Headache.
☐ Other: _____.

• On average, the symptoms of disequilibrium tend to be ☐ mild, ☐ moderate, ☐ severe, or ☐ variable in severity.

• The disequilibrium has caused me to fall: ☐ yes, ☐ no.

• I experience a "**warning**" before the symptoms of disequilibrium begin:
☐ No. ☐ Yes, and the warning signs are _____.

• My symptoms of disequilibrium tend to be **triggered** or **worsened** by (check all that apply):

☐ Rolling over in bed to the right.
☐ Rolling over in bed to the left.
☐ Bending forward.
☐ Standing up.
☐ Rapid head movements.
☐ Other changes in position of the head, neck or body, such as _____.
☐ Walking in the dark.
☐ Walking through narrow spaces (such as hallways or grocery store aisles).
☐ Walking through very wide open spaces.
☐ Elevators.
☐ Underwater diving.
☐ Sneezing, coughing, straining at stool.
☐ Traveling by ☐ car, ☐ airplane, ☐ boat.
☐ Loud noises.
☐ Bright lights.
☐ Alcohol.
☐ Caffeine.
☐ Certain foods, such as: _____.
☐ Certain smells, such as: _____.
☐ Hot showers, hot weather.
☐ Time of day, time of year, season: _____.
☐ Stress.
☐ Menstrual periods (if relevant).
☐ Other triggers: _____.

• I have tried the following strategies to treat my symptoms:

☐ Medications that HELPED the disequilibrium (please list): _____.

☐ Medications that did NOT help the disequilibrium (please list): _____.

☐ Physical therapy: _____ . This ☐ helped, ☐ didn't help.
(kind of physical therapy)
☐ Chiropractic treatment. This ☐ helped, ☐ didn't help.
☐ Acupuncture. This ☐ helped, ☐ didn't help.
☐ Alternative (non-traditional) medications, including: _____.
These alternative medications ☐ helped, ☐ didn't help.
☐ Other strategies: _____. This ☐ helped, ☐ didn't help.

• The **first time** I ever experienced these symptoms of disequilibrium was _____ .
(date)

• The **last time** I ever experienced these symptoms of disequilibrium was _____ .
(date)

• The **time pattern** of these symptoms of disequilibrium is:

☐ Constant. I experience the symptoms of disequilibrium every waking moment.
☐ Intermittent, occurring on average _____ times per ☐ hour, ☐ day, ☐ week, ☐ month, ☐ year.
(number)

The **duration** of these intermittent symptoms of disequilibrium is, on average, _____ ☐ seconds,
(number)

☐ minutes, ☐ hours, ☐ days, ☐ weeks, ☐ months.

• With regard to **driving a motor vehicle**:

☐ My symptoms of disequilibrium do not affect my driving.
☐ My symptoms of disequilibrium limit my driving, though I still do drive.
☐ My symptoms of disequilibrium completely prevent me from driving.

• Other details about my symptoms of disequilibrium that I feel are important are: _____.

Ear symptoms. If you do not have any ear symptoms at all, please skip to the next section.

	LEFT ear	**RIGHT ear**
Ear pain	Started on _____ [date].	Started on _____ [date].
Noise sensitivity	Started on _____ [date].	Started on _____ [date].
Ear fullness	Started on _____ [date].	Started on _____ [date].
Hearing loss	Started on _____ [date].	Started on _____ [date].
Hearing aid use	Started on _____ [date].	Started on _____ [date].
Abnormal sounds (also called "tinnitus")	Started on _____ [date]. The abnormal sounds in the left ear include: ☐ Ringing, ☐ Buzzing, ☐ Hissing, ☐ Music, ☐ Voices, ☐ Locusts, ☐ Crickets, ☐ Thumping, ☐ Other: _____.	Started on _____ [date]. The abnormal sounds in the right ear include: ☐ Ringing, ☐ Buzzing, ☐ Hissing, ☐ Music, ☐ Voices, ☐ Locusts, ☐ Crickets, ☐ Thumping, ☐ Other: _____.

• My ear symptoms tend to be **triggered** or **worsened** by (check all that apply):

☐ Jaw movements.
☐ Neck movements.
☐ Yawning.
☐ Sneezing, coughing, straining.
☐ Traveling in an airplane.
☐ Being in a quiet environment.
☐ Exposure to loud noises.
☐ Being in an environment with many different noises (such as a dinner party).
☐ Fatigue or sleep deprivation.
☐ Salt.
☐ Alcohol.
☐ Caffeine.
☐ Certain foods, such as: _____.
☐ Stress or anxiety.
☐ Medications, such as: _____.
☐ Other: _____.

• My ear symptoms tend to be **improved** by (check all that apply):

☐ Hearing aids.
☐ Ear plugs.
☐ Being in a quiet environment.
☐ Masking (adding various types of sound to your environment, such as music, or a fan, or radio static).
☐ Rest.
☐ Medications, such as: _____.
☐ Other: _____.

• The **time pattern** of these ear symptoms is:

☐ Constant. I experience these ear symptoms every waking moment.
☐ Intermittent, occurring on average _____ *(number)* times per ☐ hour, ☐ day, ☐ week, ☐ month, ☐ year.

The **duration** of these intermittent ear symptoms is, on average, _____ *(number)* ☐ seconds, ☐ minutes, ☐ hours, ☐ days, ☐ weeks, ☐ months.

• I have tried using masking strategies (adding various types of sound to your environment) to help my tinnitus: ☐ no, ☐ yes; in particular, I have tried: _____.
• Tinnitus interferes with my sleep: ☐ no, ☐ yes.
• Tinnitus interferes with my concentration: ☐ no, ☐ yes.

• Tinnitus makes me depressed: ☐ no, ☐ yes.
• Other details about my ear symptoms that I feel are important are: _____.

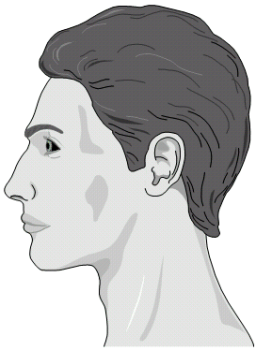
Headaches. Whether or not headache is your main symptom, please tell us about it:

• I get headaches: ☐ yes, ☐ no. If you never get any headaches at all, please skip to the next section.
• Types of headaches: I get ☐ only one type of headache, ☐ several types of headaches.

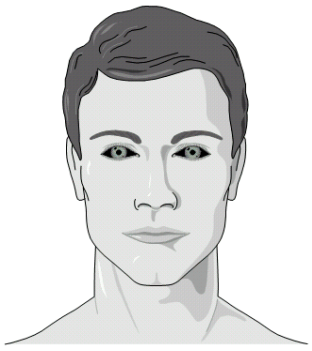
Please tell us about the **most bothersome type of headache** that you get:

• The pain of the headache tends to affect primarily this part of the head (please **indicate on the drawings**):

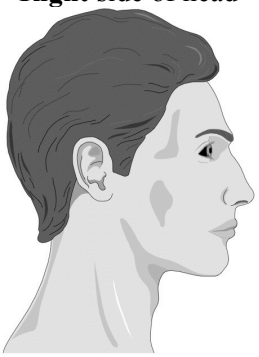
Left side of head



Face



Right side of head



• The pain of the headache ☐ stays in one place, ☐ tends to move to _____.
• The headache is usually ☐ mild, ☐ moderate, ☐ severe, ☐ variable in severity.
• The quality of the headache is ☐ sharp, ☐ dull, ☐ pressure, ☐ squeezing.
• The headache is usually ☐ throbbing/pulsating/pounding, ☐ constant.

• Immediately before, during, or immediately after the headache, I sometimes also experience the following:

☐ Changes in my vision (such as ☐ blurring, ☐ double vision, ☐ wavy lines, ☐ lights, ☐ black spots).
☐ Dizziness.
☐ Numbness or tingling.
☐ Nausea, ☐ vomiting.
☐ Sensitivity to bright lights.
☐ Sensitivity to loud noises.
☐ Sensitivity to certain smells, such as: _____.
☐ Other: _____.

• The following things tend to make the headache **worse**:

☐ Physical exertion.
☐ Movement.
☐ Other: _____.

• The following things tend to make the headache **better**:

☐ Lying in a quiet, dark room.
☐ Going to sleep.
☐ Certain medications, including: _____.
☐ Other: _____.

• The **time pattern** of the headache is:

☐ Constant. I experience the headache every waking moment.
☐ Intermittent, occurring on average _____ times per ☐ hour, ☐ day, ☐ week, ☐ month, ☐ year.
(number)

The **duration** of these intermittent headaches is, on average, _____ ☐ seconds, ☐ minutes, ☐ hours,
(number)

☐ days, ☐ weeks, ☐ months.

• The **first time** I ever remember getting this type of headache was _____ .
(date)

• The **last time** I got this type of headache was _____ .
(date)

• This headache seems to be **triggered** by:

☐ Barometric pressure changes or other weather changes.
☐ Sleep deprivation.
☐ Dehydration.
☐ Other: _____.

• For women: The headache sometimes occurs with my menstrual cycle ☐ yes, ☐ no.

• I used to get car sick easily as a child: ☐ yes, ☐ no.

• Other details about my headaches that I feel are important are: _____.

Review of systems. Please note that this section is asking about particular *symptoms* and *sensations* (not about specific medical diagnoses).

Yes	No	**Constitutional**
☐	☐	Fever
☐	☐	Weight loss of _____ pounds over a time period of _____ weeks/months (please circle)

Yes	No	**Eyes**
☐	☐	Blurry vision
☐	☐	Double vision
☐	☐	Dry eyes

Yes	No	**Nose, mouth, throat**
☐	☐	Dry mouth
☐	☐	Sores in the mouth

Yes	No	**Cardiovascular**
☐	☐	Chest discomfort
☐	☐	Palpitations

Yes	No	**Respiratory**
☐	☐	Cough
☐	☐	Discomfort breathing

Yes	No	**Gastrointestinal**
☐	☐	Difficulty swallowing
☐	☐	Stomach discomfort
☐	☐	Constipation
☐	☐	Bowel incontinence

Yes	No	**Genitourinary**
☐	☐	Bladder incontinence
☐	☐	Unusually frequent urination
☐	☐	Burning during urination

Yes	No	**Musculoskeletal**
☐	☐	Cramps
☐	☐	Muscle aches
☐	☐	Joint pain

Yes	No	**Skin and hair**
☐	☐	Unusually dry skin
☐	☐	Rashes
☐	☐	Hair loss

Yes	No	**Neurological**
☐	☐	Tremor
☐	☐	Difficulty with speech
☐	☐	Handwriting has gotten smaller

Yes	No	**Psychiatric**
☐	☐	Unusual nervousness
☐	☐	High stress

Yes	No	**Endocrine**
☐	☐	Unusually sensitive to cold
☐	☐	Unusually sensitive to heat

Yes	No	**Hematologic/lymphatic**
☐	☐	Easy bruising or bleeding
☐	☐	Swollen glands (lymph nodes) in the neck, armpit or groin

Yes	No	**Allergic/immunologic**
☐	☐	Runny nose
☐	☐	Itchy eyes

Social history:

Salt	☐ I never add salt in my diet.	☐ I add a little salt. ☐ I add an average amount of salt. ☐ I add lots of salt. ☐ I monitor my salt intake, and on average have _____ mg per day.
Alcohol	☐ I never drink alcohol.	☐ I have about _____ alcoholic drinks per week.
Caffeine	☐ I never drink anything containing caffeine.	☐ I drink _____ caffeinated beverages per week (coffee, tea, Coke, Pepsi, Mountain Dew, etc.).
Chocolate	☐ I never eat chocolate	☐ I eat chocolate about _____ times per week.
Cheese	☐ I never eat cheese	☐ I eat cheese about _____ times per week. The kinds of cheese I eat include _____.
MSG (monosodium glutamate)	☐ I specifically avoid foods containing MSG.	☐ I do eat foods containing MSG (many prepared foods, such as soups, salad dressings, Asian food, TV dinners). ☐ I'm not sure whether my diet contains foods with MSG.
Nitrites	☐ I avoid nitrites	☐ I do eat foods containing nitrites (found in deli meats, smoked fish, etc.). ☐ I'm not sure whether my diet contains foods with nitrites.

• Smoking:
- ☐ I have never smoked.
- ☐ I first started smoking on _____ (*date*), most recently stopped smoking on _____ (*date*), and smoke(d) about _____ (*number*) packs per day.

• I travel by airplane about _____ (*number*) times per year. The last time I traveled by airplane was on _____ (*date*).

• For women:
- ☐ I am pregnant now.
- ☐ I am planning pregnancy within the next year.
- ☐ I am currently breastfeeding.
- ☐ I still get my period regularly.
- ☐ I no longer have regular periods. My last regular period was on _____ (*date*).
- ☐ I had a hysterectomy (uterus removed).
- ☐ I had an oophorectomy (ovaries removed).
- ☐ I had a tubal ligation ("tubes tied").

• I sleep an average of _____ (*number*) hours per night. My sleep patterns are ☐ regular, ☐ irregular.

• I sleep on _____ (*number*) pillows.

• My preferred sleeping positions are: ☐ back, ☐ stomach, ☐ right side down, ☐ left side down.
• I sleep in these positions ☐ just out of habit, ☐ because it helps reduce some of my symptoms.
• I am: ☐ single, ☐ married, ☐ widowed, ☐ separated, ☐ divorced, ☐ I live with a domestic partner.

• My most recent job was _____ .
(job title)

• ☐ I am still working. ☐ I retired on _____ .
(date)

• I consider myself disabled due to my symptoms: ☐ yes, ☐ no.
• Regarding employment disability payments: ☐ I am not receiving disability payments, ☐ I am receiving or have received disability payments, ☐ I am applying for disability.
• I am presently involved in or planning litigation regarding my symptoms: ☐ yes, ☐ no. If yes, please provide details about the litigation:

Injuries and exposures (please check all that apply, and ***write the approximate date*** *of occurrence*):

☐ Trauma to the ear.
☐ Trauma to the head.
☐ Trauma to the neck.
☐ Whiplash injury.
☐ Other trauma: _____.
☐ Unusual exposure to loud noises.
☐ Carbon monoxide.
☐ Heavy metals (arsenic, cadmium, chromium, cobalt, manganese, lead, mercury, thallium, uranium, etc.)
☐ Other toxins (e.g., organophosphates or other pesticides): _____.

Please supply details regarding the trauma(s) or exposure(s):

Past medical history (please check all that apply, supply any details, and ***write the approximate date*** *of occurrence or diagnosis and treatment*):

Ear problems:
- ☐ Ear infections on the ☐ right side, ☐ left side.
- ☐ Tubes (tympanostomy tubes) placed in my eardrum(s).
- ☐ Hearing loss.
- ☐ Meniere's disease.
- ☐ Otosclerosis.
- ☐ Other ear problems: _____.

Constitutional:
- ☐ As a child I used to get motion sickness easily.
- ☐ As an adult I still get motion sickness easily.

Brain, spinal cord and nerves:
- ☐ Aneurysm.
- ☐ Carpal tunnel syndrome.
- ☐ Encephalitis.
- ☐ Herniated disc in the neck.
- ☐ Herniated disc in the lower back.
- ☐ Memory loss.
- ☐ Meningitis.
- ☐ Numbness or tingling, located in _____.
- ☐ Paralysis.
- ☐ Parkinsonism.
- ☐ Peripheral neuropathy.
- ☐ Seizures.
- ☐ Speech disturbance.
- ☐ Spinal stenosis.
- ☐ Stroke.
- ☐ Tremor or problems with coordination.
- ☐ Other neurological problems: _____.

Pain:
- ☐ Headaches: ☐ migraine, ☐ tension, ☐ sinus.
- ☐ Jaw pain, TMJ.
- ☐ Bruxism (grinding the teeth).
- ☐ Neck pain.
- ☐ Low back pain.
- ☐ Other pain problems: _____.

Sleep:
- ☐ Problems staying awake.
- ☐ Problems falling asleep.
- ☐ Snoring.
- ☐ Sleep apnea, currently being treated with ☐ CPAP or ☐ BiPAP.

Heart, blood, and blood pressure problems:
- ☐ Low blood pressure.
- ☐ High blood pressure.
- ☐ I take medications to control blood pressure.
- ☐ High cholesterol.
- ☐ I take medications for cholesterol.
- ☐ Heart problems: ☐ angina, ☐ heart attack, ☐ heart failure, ☐ heart stents, ☐ bypass surgery, ☐ heart valve replacement.
- ☐ Heart palpitations.
- ☐ Heart pacemaker.
- ☐ Anemia.
- ☐ Fainting
- ☐ Other cardiovascular problems: _____.

Cancer (please indicate type and treatments, such as surgery, chemotherapy, radiation):

Eye problems:
- ☐ Crossed eyes, lazy eye, strabismus.
- ☐ Poor vision on the ☐ right, ☐ left.
- ☐ I use glasses.
- ☐ I use contact lenses.
- ☐ My vision was last checked by an eye doctor on _____ (*date*).
- ☐ Cataract ☐ Removed from the right, ☐ Removed from the left, ☐ Still present on the right, ☐ Still present on the left
- ☐ Macular degeneration.
- ☐ Glaucoma.
- ☐ Retinopathy from diabetes.
- ☐ Other eye problems: _____.

Endocrine:
- ☐ Diabetes.
- ☐ Low blood sugar.
- ☐ Thyroid disease: ☐ high thyroid, ☐ low thyroid.
- ☐ Other endocrine problems: _____.

Breathing problems:
- ☐ Asthma.
- ☐ Emphysema, COPD.
- ☐ Sinusitis.
- ☐ Pneumonia.
- ☐ Deviated septum.
- ☐ Other respiratory problems: _____.

Nutritional:
- ☐ Overweight.
- ☐ Vitamin B12 deficiency.
- ☐ Vitamin D deficiency.

Stomach, intestine, and digestive problems:
- ☐ Reflux.
- ☐ Hiatal hernia.
- ☐ Ulcers.
- ☐ Irritable bowel.
- ☐ Colon polyps.
- ☐ Diverticulosis.
- ☐ Diverticulitis.
- ☐ Other digestive problems: _____.

Urinary problems:
- ☐ Kidney stones.
- ☐ Other kidney disease.
- ☐ Bladder problem.
- ☐ Enlarged prostate.
- ☐ Other urinary problems: _____.

Liver and gall bladder problems:
- ☐ Hepatitis.
- ☐ Cirrhosis.
- ☐ Gallstones.
- ☐ Other liver or gall bladder problems: _____.

Autoimmune problems:
- ☐ Multiple sclerosis.
- ☐ Lupus.
- ☐ Allergies to _____.
- ☐ Other autoimmune problems: _____.

Infections:
- ☐ HIV/AIDS.
- ☐ Other infectious problems: _____.

Bone and joint problems:
- ☐ Arthritis.
- ☐ Low bone density (whether osteoporosis or osteopenia).
- ☐ Knee replacement.
- ☐ Hip replacement.
- ☐ Amputation.
- ☐ Other bone and joint problems: _____.

Psychological:
- ☐ Depression.
- ☐ Anxiety.
- ☐ Panic attacks.
- ☐ Treatment by a psychiatrist for _____.
- ☐ Unusual amounts of stress.
- ☐ Other psychiatric problems: _____.

Reproductive:
- ☐ Erectile dysfunction.
- ☐ Infertility.
- ☐ Uterine fibroids.
- ☐ Unusual uterine bleeding.
- ☐ Other reproductive problems: _____.

Surgeries:
- ☐ Appendix removed.
- ☐ Back surgery.
- ☐ Brain surgery.
- ☐ Breast surgery.
- ☐ Carotid artery surgery.
- ☐ Cataract surgery.
- ☐ Cesarian section.
- ☐ Ear surgery.
- ☐ Gall bladder surgery.
- ☐ Hysterectomy.
- ☐ Neck surgery.
- ☐ Oophorectomy.
- ☐ Stomach surgery.
- ☐ Thyroid surgery.
- ☐ Tonsillectomy.
- ☐ Tubal ligation.
- ☐ Other surgeries: _____.

Other medical problems:

Family history

My **biological mother** is:

☐ Alive, and is currently _____ (number) years old. Her medical problems include _____.

☐ Deceased. She died when she was _____ (number) years old, and the cause of death was _____.

My **biological father** is:

☐ Alive, and is currently _____ (number) years old. His medical problems include _____.

☐ Deceased. He died when he was _____ (number) years old, and the cause of death was _____.

The following diseases **run in my family** (specify which relatives):

☐ Migraines.
☐ Convulsions or seizures.

Dizziness, balance or hearing problems:
- ☐ Balance problems.
- ☐ Hearing loss **starting before age 40**.
- ☐ Otosclerosis.
- ☐ Meniere's syndrome.
- ☐ Symptoms like my own.

☐ Brain aneurysms.
☐ Brain tumors.
☐ Stroke.
☐ Autoimmune diseases (such as ☐ multiple sclerosis, ☐ lupus, ☐ rheumatoid arthritis, ☐ ankylosing spondylitis, ☐ Sjögren's syndrome, ☐ Behçet's disease).
☐ Neurodegenerative disorders (such as ☐ Parkinson's disease, ☐ Alzheimer's, ☐ hereditary ataxia).

☐ Other diseases that run in the family: _____.

People of various **ancestries** or **ethnic backgrounds** may be more genetically susceptible to developing specific illnesses. For this reason, we ask about your ethnic background, although you are not obliged to answer this. My ethnic background is: _____.

Allergies:

• I am allergic to the following medications (list each medication and its allergic reaction):

• I am allergic to the following environmental agents: _____.

Medications. I am **currently** taking the following medications (please include vitamin supplements, oral contraceptives, herbal supplements). *For each medication please list the name, dose, how many times per day you take it, the approximate date that each medication was **started**, and the reason for which it was prescribed.*

Name of medication	Dose	Times per day	Date started	Purpose

Other medications or therapies hat I have taken in the past 5 years for this problem or for others (please indicate the approximate dates on which each treatment was *started* and *stopped*):

Name of medication	Dose	Times per day	Date started	Date stopped	Purpose

I have received the following medications at some point in my life (please indicate approximate **dates** and **duration** of treatment):

- ☐ Aspirin in **LARGE** doses (more than 2000 mg per day).
- ☐ Cisplatin (for cancer).
- ☐ Furosemide (Lasix®).
- ☐ Gentamicin (antibiotic).
- ☐ Kanamycin (antibiotic).
- ☐ Malaria drugs (quinine, Malarone®, Larium®).
- ☐ Nifedipine (Procardia®).
- ☐ Quinidine (for malaria).
- ☐ Streptomycin (antibiotic).
- ☐ Tamoxifen (breast cancer).
- ☐ Tobramycin (antibiotic).
- ☐ Vancomycin (antibiotic).

Previous tests and studies. Please indicate if you have ever had any of these tests, when they were done, and what the results were. If you have the films or official reports, please provide them.

Ear and balance tests:
☐ Hearing test (audiogram), date _____, result:
☐ BAER (evoked potential test), date _____, result:
☐ OAE (specialized hearing test), date _____, result:
☐ VEMP, date _____, result:
☐ ENG caloric test (hot and cold, water or air, in the ear), date _____, result:
☐ Rotatory chair test (spinning test), date _____, result:
☐ ECoG (evoked potentials for Meniere's syndrome), date _____, result:
☐ Posturography (balance test), date _____, result:

X-rays, CT scans, MRI:
☐ Brain MRI or MRA, date _____, result:
☐ Brain CT, date _____, result:
☐ Neck MRI, date _____, result:
☐ Neck CT, date _____, result:
☐ CT scan of inner ear (temporal bone CT), date _____, result:
☐ Sinus X-rays or CT, date _____, result:
☐ Chest X-ray, date _____, result:

Neurological tests:
☐ Carotid doppler, date _____, result:
☐ Cerebral angiogram, date _____, result:
☐ Lumbar puncture, date _____, result:
☐ EEG (brain wave test), date _____, result:
☐ EMG & NCV (nerve conduction test), date _____, result:

Other medical tests:
☐ Recent general medical checkup, date _____, result:
☐ Recent general blood tests (blood count, glucose, cholesterol), date _____, result:
☐ Heart testing (EKG, echocardiogram, stress test, Holter monitor), date _____, result:
☐ Tilt table test, date _____, result:
☐ Sleep study, date _____, result: