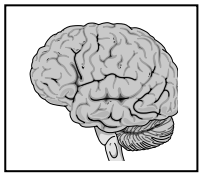
NEUROLOGY QUESTIONNAIRE



Chicago Dizziness and Hearing
645 N. Michigan, Suite 410
Chicago, Illinois, 60611

NAME	
AGE	
TODAY'S DATE	
SOCIAL SEC #	

SEND REPORT TO:

HOME PHONE	
WORK PHONE	
PHARMACY	
PATIENT'S FAX	
Email	

YOUR ADDRESS:

Sex:__M__F Birthdate:___/___/___ ___Single___Married___Widowed___Separated___Divorced

Patient Employed by:_____

Business Address:Street_____City_____State____Zip_____

Primary Insurance:_____ Card Holder Name:_____

Secondary Insurance:_____ Card Holder Name:_____

Sign below to indicate that:

1. We offered you a copy of our Privacy Policy statement for your review
2. We have your permission to ask your doctor for records related to the reason for this appointment
3. I hereby authorize the release of any information needed by my carrier to process the claim. I understand that I am financially responsible for all charges; these may include, but are not limited to, deductibles, co-pays, and "non-covered services".
4. We have your permission to use video material of your eye (where you cannot be recognized) in research or educational works.

Signature _____

Please answer the following questions and bring the answers to your appointment. There is room at the end of each section for additional comments. Please give necessary details for "yes" answers. We realize that this form is long, but when it is filled out carefully it allows us to devote more time to examining you.

NEUROLOGY QUESTIONNAIRE

1. Present Illness I am here because of (circle all that apply)

Confusion/Memory loss

Pain (other than headache – there is another questionnaire for that)

Visual problem or Nystagmus (jumpy eyes)

Seizures/Spells

Weakness/Numbness

Other _____

Note: if you are seeing the doctor for a different reason, such as dizziness/ hearing problems or headaches, ask the receptionist for the proper questionnaire.

My symptoms started on:

Are the main symptoms constantly present, or do they appear in attacks?

If in attacks,

how often?

how long?

Do you have any warning that an attack is about to start?

4. **Life Style**

How much alcohol do you *drink per week*?

How much do you *smoke per day*?

How much *salt* do you use on your food?

What sort of *work* do you do (or used to do)?

How often do you *fly on airplanes*?

Are you presently in litigation or planning litigation about symptoms related to this visit?

Are you disabled due to your condition?

(Women of childbearing age only) are you
pregnant?
Perimenopausal?

5. **Injuries** (circle, explain)

ears

Eyes

head (for example, concussion)

Neck

6. **Exposure** (circle)

Poisons, gases, chemicals

Tropical diseases

Insect bites/tick bites

Blood transfusions within 5 years

7. Past or present health has been affected by (circle)

Constitutional

Weight Loss (15 LB or more)

Trouble sleeping?
Due to dizziness?
Due to depression?

CARDIOVASCULAR

Anemia

Fainting

Heart problems

High cholesterol

High blood pressure

Low blood pressure

Diabetes

Palpitations (abnormal or fast beating) of the heart

CANCER

What type and when?

ENDOCRINE

Low sugar (hypoglycemia)

Thyroid disorder

PSYCHOLOGICAL

Treatment by a psychiatrist or counselor

Depression

Unusual amounts of stress

PAIN

Arthritis

Pain in back of jaw (TMJ)

Migraine, Sinus or tension headaches

Low Back Pain

Neck Pain

IMMUNOLOGIC

Allergy (to what?)

Lupus/other autoimmune disease

BREATHING PROBLEMS

Asthma

Pneumonia

Sinusitis

Deviated Septum

STOMACH PROBLEMS

Ulcer

Reflux/Hiatal Hernia

Irritable bowel

EYE PROBLEMS (other than glasses)

Crossed eyes, lazy eye

Poor vision in one eye

Cataract

Macular Degeneration

Double vision?

NEUROLOGICAL PROBLEMS

B12 Deficiency

Carpal Tunnel

Memory loss

Meningitis

Multiple Sclerosis

Pins and needles, numbness (where)

Muscle, paralysis or weakness (where)

Seizures

Speech disturbance

Tremor or incoordination

RENAL/GENITOURINARY

Bladder Problem

Sexual function problem

Kidney problem

8. SURGERY

☐ Appendix	☐ Breast	☐ Cataract	☐ Carotid
☐ C-Section	☐ Ear	☐ Epidural Injection	☐ Gall Bladder
☐ Hysterectomy	☐ Prostate	☐ Sinus	☐ Stomach
☐ Tonsils			

Other _____

FAMILY HISTORY

9. Are there any **family members** with (circle, list):

Aneurysms

Balance problems, Vertigo or Dizziness

Convulsions or seizures

Diabetes

Hearing loss

Heart disease or high blood pressure

Migraine headaches

Meniere's syndrome

Multiple Sclerosis

Psychiatric problems

Symptoms like your own

Other diseases that run in the family? (please list)

What is your ancestry? (some ancestries are more prone to develop dizziness)

MEDICATIONS

10a. What are your current medications, include hormones, allergy shots, birth control pills, vitamins, etc. (Name and amount/day)?

1.
2.
3.
4.
5.
6.
7.
8.
9.
10...

10b. What other medications have you taken in the last 5 years, for this problem or others?

1.
2.
3.
4.
5.

10c. Have you undergone physical therapy for your condition? ☐
Chiropractic treatment? ☐
Acupuncture? ☐
Alternative medicines (such as Ginkgo, St. Johns Wort?) ☐

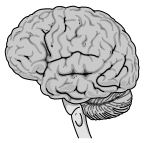
10d. **Have you ever taken any of the following drugs? Mark the ones that you have taken.**

☐ Amiodarone (a heart drug)
☐ Cisplatin (for cancer)
☐ Dilantin (for seizures)
☐ Xanax (for anxiety)

☐ chemotherapy ?
☐ immunosuppressants ?

PREVIOUS STUDIES

11. Have you had any of these tests? (date if done and note result if known)



NEUROLOGICAL TESTS

- ☐ Carotid Doppler
- ☐ Cerebral angiogram
- ☐ EEG (Brain wave test for seizures)
- ☐ Lumbar puncture (spinal fluid examination, spinal tap)

GENERAL MEDICAL TESTS

- ☐ Recent general medical checkup?
- ☐ Recent general blood tests
  - blood count,
  - Cholesterol
  - Glucose,
  - Thyroid tests
- ☐ Heart testing (EKG, Echo, Stress test, Holter Monitor)
- ☐ Tilt table test

X-RAYS

- ☐ Brain angiogram
- ☐ Chest X-ray
- ☐ Ear: CT scan of inner ear (Temporal bone CT)
- ☐ Head: MRI, MRA and/or CT scan
- ☐ Head: CT scan
- ☐ Neck: X-rays, CT or MRI scan
- ☐ PET scan
- ☐ Sinus: X-rays or CT scan

Other Important Tests:

THANK YOU !