

# ENT SURGICAL GROUP, P.C.

Riverview Medical Building

423 Third Avenue

Kingston, PA

(570) 714-3434

## PATIENT QUESTIONNAIRE

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Print name Last First Middle initial

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Occupation: \_\_\_\_\_

Family and/or Referring Physician: \_\_\_\_\_

.....

### INITIAL PROBLEM & DESCRIPTION

Problem(s) you are seeking help with: \_\_\_\_\_

When did the problem(s) begin? \_\_\_\_\_

What were the initial symptoms and circumstance? \_\_\_\_\_

What have you been told your problem is due to? \_\_\_\_\_

What do YOU think your problem is due to? \_\_\_\_\_

Do you feel any of the following? Have these feelings changed since the problem began?

	<u>Yes</u>	<u>No</u>	<u>Feeling Is Gone</u>	<u>Somewhat Improved</u>	<u>Somewhat Worse</u>	<u>No Change</u>
Giddy	___	___	___	___	___	___
Lightheaded	___	___	___	___	___	___
Disoriented	___	___	___	___	___	___
Spinning	___	___	___	___	___	___
Tumbling	___	___	___	___	___	___
Rocking	___	___	___	___	___	___
Tilted	___	___	___	___	___	___
Other _____	___	___	___	___	___	___

# Patient Questionnaire

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### INITIAL PROBLEM & DESCRIPTION (continued)

How often do spells occur?     Constantly                      Monthly ( times/month)  
                                           Daily                                      Yearly ( times/month)  
                                           Weekly ( times/week)

When are the symptoms mostly present?  
                                           Walking                       Standing                       Sitting  
                                           Lying down                       Anytime

**Please check the following:**

	<u>Yes</u>	<u>No</u>	<u>During a spell</u>
Do you have difficulty with balance?	___	___	___
Have you fallen?	___	___	___
Do you have a sensation of spinning or tumbling?	___	___	___
Do you have a sensation of rocking or swaying?	___	___	___
Do you ever feel pulled to the ground?	___	___	___
Do you feel lightheaded, about to faint or black out?	___	___	___
Have you lost consciousness (fainted or blacked out)?	___	___	___
Do you experience nausea or vomiting?	___	___	___
Do you have double vision?	___	___	___
Do you have visual symptoms (jagged lines or loss)?	___	___	___
Does your vision jump while walking or riding?	___	___	___

**Is the dizziness or vertigo brought on or worsened by:**

	<u>Yes</u>	<u>No</u>
Lying down or rolling over in bed?	___	___
Sitting up or standing up?	___	___
Walking in the dark or on uneven surfaces?	___	___
Hot baths or showers?	___	___
Menstrual cycle?	___	___
Exercise?	___	___
Reaching or bending?	___	___
Reading?	___	___
Loud Noises?	___	___

# Patient Questionnaire

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### INITIAL PROBLEM & DESCRIPTION (continued)

	<u>Yes</u>	<u>No</u>
Coughing, sneezing, straining, or blowing your nose?	___	___
Turning your head while walking?	___	___
Supermarket aisles, malls, tunnels, bridges, or heights?	___	___
Automobile rides?	___	___
Windshield wipers?	___	___
Restaurants or movie theaters?	___	___

### HEARING & TINNITUS

Do you have hearing loss in the right ear, left ear, or both? \_\_\_ Right \_\_\_ Left \_\_\_ Both

Does your hearing fluctuate? \_\_\_ Yes \_\_\_ No

Do you have tinnitus (ringing) in the ear? \_\_\_ Right \_\_\_ Left \_\_\_ Both

Is the tinnitus high pitched or low pitched? \_\_\_ High \_\_\_ Low

Is the tinnitus constant, brief, or cricket-like? \_\_\_\_\_

Do you experience the following:

Right ear: \_\_\_ Pain \_\_\_ Pressure \_\_\_ Fullness \_\_\_ Popping \_\_\_ Clicking

Left ear: \_\_\_ Pain \_\_\_ Pressure \_\_\_ Fullness \_\_\_ Popping \_\_\_ Clicking

Have you had:

\_\_\_ Frequent ear infections \_\_\_ Injuries to the ear \_\_\_ Discharge or draining

\_\_\_ Ear surgeries \_\_\_ Perforated or torn eardrum