

David S. Zee, M. D.
OCULOMOTOR/VESTIBULAR LABORATORY

QUESTIONNAIRE

This questionnaire will become a permanent part of the patient's medical record.

TODAY'S DATE: _____

NAME: _____

ADDRESS: _____

DOB: _____

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____

EMAIL ADDRESS: _____

DR. ZEE HAS MY PERMISSION TO COMMUNICATE HEALTH INFORMATION

VIA EMAIL. IF YES _____ SIGN HERE _____ NO _____

ARE YOU RIGHT _____ OR LEFT _____ HANDED?

PRESENT OCCUPATION: _____

PRIOR OCCUPATIONS: _____

EDUCATION (HIGHEST LEVEL): _____

REFERRING PHYSICIAN:

NAME: _____

ADDRESS: _____

PHONE: _____

FAX: _____

PRIMARY CARE PHYSICIAN:

NAME: _____

ADDRESS: _____

PHONE: _____

FAX: _____

(The patient will always receive a copy of the report. Please attach an additional page for any one else you would like to receive a copy.)

5. Please mark each symptom and give details for all yes answers:

<u>YES</u>	<u>NO</u>	
___	___	Trouble with walking?
___	___	Trouble with balance?
___	___	Any falls?
___	___	Difficulty turning over in bed?
___	___	Sense of motion of the environment?
___	___	Sense of motion of one's own body?
___	___	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? (which direction)
___	___	Spinning inside of one's head?
___	___	Sense of walking on pillows?
___	___	Lightheadedness or faintness?
___	___	Fear or avoidance of public places?
___	___	Sweating?
___	___	Nausea?
___	___	Vomiting?
___	___	Impaired vision?
___	___	-Double vision?
___	___	-images separated side-to-side?; up and down, tilted?
___	___	-Blurred vision?
___	___	-Flashes of light?
___	___	-Jumping of vision? (when walking or riding?)
___	___	-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?

8. How is your dizziness or imbalance affected or brought on by (give details):

Severely Moderately Not at all

_____	_____	_____	Turning over in bed?
_____	_____	_____	Bending over, looking up?
_____	_____	_____	Standing up quickly?
_____	_____	_____	Rapid head movements?
_____	_____	_____	Walking in the dark?
_____	_____	_____	Walking on uneven surfaces (eg. grass or sand)?
_____	_____	_____	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)?
_____	_____	_____	Moving your eyes with your head still?
_____	_____	_____	Are you dizzy with 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 type or specific place?
_____	_____	_____	Exercise (eg. 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, or stress? GIVE DETAILS
_____	_____	_____	Menstrual periods?

DETAILS:

9. Other Questions Concerning Dizziness:

YES NO

- Can you bring on your dizziness voluntarily? (if yes, please give details)
 Did you ever or do you have moderate to severe motion sickness?
 (car or boat, please describe)
 Did or do you ice skate, perform 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?
 Sinus disease?
 Inner ear disease (eg. labyrinthitis)?
 Difficulty with your hearing? (which ear and what type of difficulty?)
 Pain, fullness, popping or pressure in the ear? (which ear?)
 Ringing in the ears? (Tinnitus)

 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 six months: _____

Pain intensity (1 to 10 with 10 the most severe): _____

B. If yes, do your headaches usually:

YES NO

- Last 4 hours or more?
 Start on one side of the head? (front, back, left or right?)
 Throbbing or pulsatile (with the heart beat) in quality?
 Severe enough to interfere with your schedule?
 Related to diet?
 Related to menstrual periods?
 Aggravated by physical activity such as climbing stairs)?
 Brought on by cough, sneeze, laughing or strain?
 Associated with nausea and/or vomiting?
 Aggravated by bright lights or loud noises?
 Preceded by bright or flashing lights or zigzag lines?

YES NO

Usually relieved by going to a dark room?
 Usually relieved by sleep?
 Require medications? (which medications and how often?)
 Do you take pain medication more than 2 times per week?

12. Circle and give details of symptoms you have had in the last few years:

Strength or energy change	Appetite change
Weight change (gain or loss, how much & over what period)	
Memory loss (amnesia)	Change in handwriting
Skin rash or birthmarks	Sores in mouth or genitals
Numbness in arms or legs	Lump in throat
Muscle aches	Joint aches
Diarrhea	Heart palpitations
Loss of bowel control	Loss of bladder control
Changes in sexual function	Fevers or Chills
Swollen glands	Problems with going to or staying asleep
Snoring or Sleep Apnea	Excessive daytime sleepiness or naps
Abnormal menstrual periods	Shortness of breath
Trouble chewing, swallowing	Sweating
Change in speech	Tremor or shakiness
Stiffness	Incoordination

13. Have you had any injuries? (if yes, please explain)

YES NO

Ears?
 Eyes?
 Retinal detachment?
 Head?
 Neck (eg. whiplash)?
 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)

<u>YES</u>	<u>NO</u>	
___	___	Poisons, gases, chemicals, or carbon monoxide?
___	___	Tropical diseases?
___	___	Tick bites?
___	___	Long term (more than a week) intravenous antibiotics?
___	___	Military service overseas? (where?)
___	___	Travel to Central or South America, Asia, Africa?
___	___	AIDS?
___	___	Blood transfusions?
___	___	Loud Noise? (eg. guns, machinery, loud music?)
___	___	Drug therapy for cancer? (eg. Chemotherapy) (what type?)
___	___	Medication for depression, anxiety, or other psychiatric disease? (Lithium, Valium or ativan, Dilantin, Tegretol, sleeping pills, antidepressants, tranquilizers? (WHAT TYPE, REASON, WHEN, HOW LONG?) SEE also item 17.

16. Has your past or present health been affected by: (if yes, please give details)

<u>YES</u>	<u>NO</u>	
___	___	Treatment by a psychiatrist or counselor?
___	___	Depression, thought of harming yourself, feelings of worthlessness? Crying spells?
___	___	Stress?
___	___	Eating disorders or phobias?
___	___	Anxiety or panic attacks?
___	___	Heart problems?
___	___	Diabetes?
___	___	Low sugar (hypoglycemia)?
___	___	Thyroid disorders?
___	___	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?
___	___	Arthritis?
___	___	Neck pain?
___	___	Lumps in breasts or testicles?

17. Have you had any of the following infections? (if yes, please give details)

<u>YES</u>	<u>NO</u>	
___	___	Syphilis or other sexually transmitted disease?
___	___	Mononucleosis (Epstein-Barr)?
___	___	Lyme disease?
___	___	Meningitis?
___	___	Other infections?

18. List all major illnesses, injuries, surgeries or miscarriage not described above:

19. On the attached medication form, please list all of your current medications (include all medications, hormones, birth control pills, over the counter meds, vitamins, Viagra or similar medications, herbal medicines, other ALTERNATIVE THERAPIES and AMOUNT/DAY:

20. What other medications have you taken for your dizziness?
include dosage, when, for how long, and effectiveness:

_____	_____
_____	_____
_____	_____
_____	_____

21. List all known allergies, including those to medication, 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, how many packs/day? _____
		What age did you start? _____
		If you quit, at what age? _____
_____	_____	Do or did you ever use drugs? LSD?, Cocaine?, Crack?, Marijuana?
_____	_____	Do you drink coffee, decaf or sodas frequently?
_____	_____	Do you use salt or eat salty foods?
_____	_____	Do you have an unusual diet? Vegetarian?

What are your pets?

What are your hobbies?

What is your favorite book?

Are you married? divorced? widowed? single?

Do you live alone?

23. Personality – Would you describe yourself as:

Obsessive
Compulsive
Prone to anxiety
Hypochondriac

Manic
Down or depressed
Melancholy or blue
Phobic

Do you set your watch ahead? How much?

24. FAMILY HISTORY

Do you have children? If so, what are their ages? their health?

Do you have brothers or sisters? If so, what are their ages? their health?

Do you have any family members with: (please indicate which family member, include also Grandparents, Aunts, Uncles, Nieces, Nephews and Cousins)

<u>YES</u>	<u>NO</u>	
___	___	The same condition that 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?
___	___	Other neurologic diseases?
___	___	Any other conditions that run in the family?
___	___	Mental retardation?

If your parents, brothers, sisters, or any children have died, at what age and from what cause?

25. Have you had a:

<u>YES</u>	<u>NO</u>		<u>RESULT?</u>	<u>WHEN?</u>
___	___	Hearing test?	_____	_____
___	___	Evaluation by a neurologist?	_____	_____
___	___	Evaluation by an ear doctor?	_____	_____
___	___	Evaluation by an eye doctor?	_____	_____
___	___	Caloric test? (water or air in ear)	_____	_____
___	___	MRI?	_____	_____
		Was contrast given by injection? _____		
___	___	Brain Arteriogram?	_____	_____
___	___	Carotid artery blood flow study?	_____	_____
___	___	BAER? (auditory evoked potentials)	_____	_____
___	___	VER? (visual evoked potentials)	_____	_____
___	___	Sinus x-rays?	_____	_____
___	___	Neck x-rays?	_____	_____
___	___	MRI of neck or spine	_____	_____
___	___	CT scan of the head or neck or spine?	_____	_____
___	___	Spinal fluid examination	_____	_____
___	___	EEG (Brain wave)	_____	_____

26. Have you recently had:

<u>YES</u>	<u>NO</u>		<u>RESULT?</u>	<u>WHEN?</u>
___	___	Blood work?	_____	_____
___	___	Urinalysis?	_____	_____
___	___	Chest x-ray?	_____	_____
___	___	Mammogram?	_____	_____
___	___	GYN (pelvic) exam?	_____	_____
___	___	Echocardiogram?	_____	_____
___	___	Holter monitor (24 hours)?	_____	_____
___	___	Tilt table test?	_____	_____
___	___	Electrocardiogram	_____	_____
___	___	Lyme test?	_____	_____
___	___	Glucose tolerance test?	_____	_____
___	___	B12 test?	_____	_____
___	___	Thyroid test?	_____	_____
___	___	AIDS test?	_____	_____

27. Handwriting specimen: Please write "Whether or not you leave here early does not matter".

28. ADDITIONAL COMMENTS: