MRN

CHART NO

NAME

DOB

Patient Stamp Above


**BROWARD ENT**
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# Patient Information Form

To provide rapid service with a minimum number of visits to our office, you are requested to complete this questionnaire before your first visit to the Dizzy Clinic. This form will provide some initial information for your physician to review before meeting you. Please try to answer all questions as completely as you can. Don't worry if you are uncertain about some of the information, as you will discuss it at your meeting with the physician.

Name: ______________________________ Date: ______________

Describe as best you can, the sensations of dizziness or imbalance you experience: ______________________________

______________________________

______________________________

______________________________

When was the first time this happened? ______________________________

What were doing at that time? ______________________________

______________________________

______________________________

______________________________

Is this dizziness constant or does it occur in "spells"? ______________________________

If there are spells, how long do the servere ones last? ______________________________

Do any of following occur with the spells: Changes in hearing? ❑ Yes ❑ No

Noises in one or both ears? ❑ Yes ❑ No Pressure one or both ears? ❑ Yes ❑ No ______________

Nausea? ❑ Yes ❑ No Vomiting? ❑ Yes ❑ No Diarrhea? ❑ Yes ❑ No

Are there other symptoms during the spells? If so, describe them: ______________________________

______________________________

______________________________

Do you have headaches? ❑ Yes ❑ No If yes, how often do you have them? ______________________________

If yes, describe a typical headache: ______________________________

______________________________

Do you have any ear or hearing problems? ❑ Yes ❑ No If yes, describe them: ______________________________

______________________________

______________________________

______________________________

Do you have any problems with: Swallowing? ❑ Yes ❑ No Speech? ❑ Yes ❑ No Double vision? ❑ Yes ❑ No

Numbness or tingling on any body part? ❑ Yes ❑ No Weakness of any body part? ❑ Yes ❑ No

If yes to any of the above, please describe: ______________________________

______________________________

______________________________