



Boston Children's Hospital



**HARVARD MEDICAL SCHOOL
TEACHING HOSPITAL**

Balance and Vestibular Program

Department of Otolaryngology and Communication Enhancement
Boston Children's Hospital at Waltham
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Telephone: 781-216-2799 Fax: 781-216-3155

Do not take any of the following medications for at least 24 hours prior to your appointment. If you have any questions or concerns about stopping any of your medications, please contact your physician.

Sedative, Anti-Depressant, Anti-Convulsant:

Ambien (Zolpidem)
Ativan (Lorazepam)
Dalmane (Flurazepam)
Dilantin (Pheytion)
Doral (Quazepam)
Elavil (Amitriptyline)
Halcion (Triazolam)
Klonopin (Clonazepam)
Librium, Librax (Chlordiazepoxide)
Lithium
Nembutal (Pentobarbital)
Pamelor (Nortriptyline)
Phenergan (Promethazine)
Placidyl (Ethychlorvynol)
Prosom (Estazolam)
Restoril (Temazepam)
Seconal (Secobarbital)
Serax (Oxazepam)
Tegretol (Carbamazepine)
Unisom (Doxylamine)
Valium (Diazepam)
Xanax (Alprazolam)

Anti-Dizziness:

Antivert, Bonine (Meclizine)
Benadryl (Diphenhydramine)
Dramamine (Dimenhydrinate)
Transderm Scop patches
Vontrol (Diphenidol)

Headache:

Fiorinal
Fioricet (Butalbital)

Stimulant:

Amphetamine
Ritalin (Methylphenidate)

*****DO NOT stop taking a medication if it does not appear on the list above.***
Xanax and Klonopin should not be stopped if it was prescribed for anxiety disorders.**

Please complete this questionnaire and fax it to us at 781-216-3155 as soon as possible. You may also e-mail it to us at: laura.cadman@childrens.harvard.edu. This questionnaire is very helpful for us in evaluating your symptoms and will facilitate us in scheduling you for an appointment in a timely manner.

Section A: General Information

A1. Name: _____

A4. Date of Birth: _____

A2. E-mail: _____

A5. Phone Number: _____

A3. Right or Left Handed: _____

Section B: Dizziness

B1. How long have you been having your symptoms? _____

B2. Please describe your dizziness:

Feeling of imbalance/unsteadiness

Spinning

Internal feeling of movement

Light-headedness

Sense of swaying, rocking or tilting

If yes to any of the above symptoms, do you move in any particular direction? _____

Other, please describe: _____

B3. Did your dizziness first begin suddenly or gradually?

Suddenly

Gradually

B4. Are your symptoms constant or intermittent?

Constant

Intermittent

B5. How frequent are the episodes? _____

B6. How long do the episodes last? _____

Seconds

Hours

Minutes

Days

B7. Have you had any falls? If yes, do you fall in a certain direction? _____

B8. Which factors provoke your episodes/make your dizziness worse?

Change in head/body position

Menstrual cycle

Travel

Exhaustion/lack of sleep

Stress/anxiety

Walking in the dark or on an uneven surface

Foods/missing a meal

Noise

Other, please describe: _____

B9. Are your symptoms changing over time? (ie: getting better, worse, staying the same)

B10. Were your symptoms initially caused by something you can identify? (ie: head trauma, ear infection, viral infection?)

Section C: Associated Symptoms

Please select any of the following symptoms you may be having:

C1. Otologic:

- | | |
|--|--|
| <input type="checkbox"/> Change in hearing | <input type="checkbox"/> Pain/pressure or fullness/plugging in ear |
| <input type="checkbox"/> Tinnitus (noise/ringing in ear) | <input type="checkbox"/> Drainage (fluid leakage) from ear |

C2. Neurologic:

- | | |
|--|---|
| <input type="checkbox"/> Sensitivity to light or sound | <input type="checkbox"/> Change in thinking (ie: memory, concentration) |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness in face |
| <input type="checkbox"/> Trouble swallowing | <input type="checkbox"/> Slurred Speech |
| <input type="checkbox"/> Numbness or weakness in arms/legs | <input type="checkbox"/> Trouble urinating or moving bowels |
- Visual symptoms (ie: blurry vision, loss of vision, double vision) or illusion that the world is moving. If yes, does this occur more often when you are moving or when you are not moving?
-

C3. Systemic:

- | | |
|---|--|
| <input type="checkbox"/> Weight gain/loss | <input type="checkbox"/> Heat/cold intolerance |
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Sweats/chills | <input type="checkbox"/> Nausea/vomiting |

C4. Other: please use this space to describe any other symptom you may be having that is not listed above:

Section D: Work-up

D1. Have you had any of the follow? If yes, what was the result, and when was it done? Please bring any medical records you have regarding these things.

- Evaluated by a specialist (ie: neurologist, ear or eye doctor): _____
What are their names? _____
- Hearing test: _____
- Caloric test (water in the ear, ENG): _____
- Rotary test: _____
- Electrocochleogram (EcoG): _____
- VEMP: _____
- CT or MRI of head or spine (was dye injected): _____
- EEG: _____
- Evoked potentials (BAER, VER): _____
- Blood work: _____

Section E: Treatment

How has your dizziness been treated to date? If you've had any of the following, when did you take them, what were the doses, and did they help you?

E1. Medication:

Antivert (Meclizine): _____

Valium (Diazepam): _____

Clonopin (Clonazepam): _____

E2. Vestibular physical therapy: _____

E3. Other treatments: _____

Section F: Past Medical History

F1. Do you have any known medical conditions?

F2. Are you on any medications? If yes, please list all of your current medications with their dosages:

F3. Have you ever had a head injury?

F4. Do you have a history of multiple ear infections, ear tubes, or ear surgery?

F5. Have you ever been exposed to intravenous (not oral) antibiotics or chemotherapy?

F6. Did you meet your developmental milestones on-time?

Section G: Family History

G1. Does anyone in your family have problems like yours?

G2. Are there any medical problems that run in your family?

G3. Does anyone in your family have migraines or headaches?

G4. How many brothers and sisters do you have? What is their health?

Section H: Social History

H1. Do you/have you ever: Smoked?
 Used alcohol?
 Used other drugs?

H2. Do you eat much salt in your diet? _____

H3. Do you ingest caffeine (coffee, soda, tea)? _____