GOOD SAMARITAN
MEDICAL CENTER

Registration Form

Name:____ Date of Birth: ________________________
Last First Middle Initial

Home/Mailing Address:____
Street City State Zip Code

Home Phone: ________________________________ Cell Phone:_____________________________

Email Address:____

Primary Care Provider:____

Race:____

Country of Origin:____

Religious Preference (if any):____

Employment Status:

- ☐ **Full-Time Employed**
- ☐ **Part-Time Employed**
- ☐ **Self-Employed**
- ☐ **Retired**
- ☐ **Student**
- ☐ **Not Employed**

Marital Status:

- ☐ **Married**
- ☐ **Single**
- ☐ **Widowed**
- ☐ **Separated**
- ☐ **Divorced**
- ☐ **Significant Other**
- ☐ **Domestic Partner**
- ☐ **Other**

Emergency Contact:

Name:_______________________Relationship:________________ Phone: ____________________

Patient Questionnaire

Legacy Good Samaritan Hospital
Audiology & Vestibular Lab
1040 NW 22nd Ave., #460
Portland, OR 97210
Phone: (503) 413-8154
Fax: (503) 413-6944

Please complete the questions as best as you can. The information will assist us in making your appointment as effective as possible. **Thanks for helping us to help you!**

Name: ________________________________

Briefly state the problem for which you are seeking help:

____

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When did your symptoms first begin (no matter how long ago)?

____

Was there a specific event or change that you think may have caused or triggered your symptoms?

(e.g., Did your symptoms begin following a cruise or boating trip, exposure to toxic fumes, head injury, neck or back injury, automobile accident, change in medications, stroke, new glasses, cataract surgery, severe stress, illness, etc.?)

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Note: If you have imbalance and/or falls without any dizziness or spinning vertigo, many of the following questions may not apply. However, please fill out the questionnaire as completely as possible since certain questions may still be helpful to us in determining the cause of your imbalance and selecting the most appropriate treatment options.

I. Do you experience any of the following symptoms? Please check (☑) all that apply.

☐ Spinning or whirling sensation. ☐ Sudden tilting sensation.

☐ Spinning or whirling sensation when you move or change positions? (e.g., rolling over in bed, bending over, tilting head back, sitting up, standing up).

☐ If you get a spinning sensation, how long does it last?

☐ 60 seconds or less ☐ Minutes ☐ Hours ☐ Days

☐ Lightheadedness.

☐ Disoriented or spacey feeling.

☐ Fainting spells.

☐ Sensation of rocking on a ship or in an earthquake.

☐ Loss of balance when walking.

☐ Tendency to veer off-course when walking. ☐To the right? ☐To the left? ☐Either direction?

☐ Loss of balance when: ☐Looking up? ☐Bending over?

☐ I have trouble walking: ☐In the dark. ☐On uneven surfaces.

☐ I must support myself when standing.

☐ Do you have a fear of falling?

☐ Imbalance with falls. If so, how many times have you fallen in the last year? _______

☐ Headache ☐ Head pressure

☐ Nausea ☐ Nausea with vomiting

☐ Memory and concentration difficulties.

☐ Visual problems: ☐ Double vision. ☐ Visual bouncing when walking.

☐ Blurring or visual lag when turning your head.

☐ Do you have an unusual ability to hear body noises? (e.g., "I can hear my eyes blink".)

II. Please check (☑) all that apply:

☐ My symptoms are constant.

☐ My symptoms occur in episodes. How often? ________________________________

☐ My symptoms occur suddenly, without warning.

☐ My symptoms occur with warning signs prior to more severe symptoms.

☐ I am symptom-free between episodes.

III. Please check (☑) any of the following that can trigger or worsen your symptoms:

☐ Worse in morning. ☐ Worse in evening. ☐ Weather changes ☐ Stress

☐ Head and body position changes ☐ Turning your head while walking

☐ Busy visual patterns/complex visual environments ☐ Grocery/mall shopping

☐ Peripheral motion ☐ Car travel ☐ Riding on elevators

☐ Altitude changes ☐ Airplane flights ☐ Menstruation/fluid retention

☐ Hearing loud noises ☐ Eating salty meals or snacks

☐ Coughing, sneezing, lifting, blowing your nose, or bowel movements

☐ I am unable to identify any specific triggers.

IV. Do you have any of the following symptoms? If so, please circle the ear involved.

☐ Difficulty in hearing? Both ears Right ear Left ear

When did you first become aware of hearing loss? ____________________

Was the hearing loss ☐ Sudden? ☐ Gradual?

Is it getting worse? _____________ Does your hearing fluctuate? ____________________________

☐ Noise in your ears? Both ears Right ear Left ear

Approximate date/year it began? _____________________ ☐ Constant? ☐ Off and on?

Sounds like: Ringing Roaring Buzzing Crickets Hissing Pulsing

Does the noise change with dizziness? If so, how? ____

____

☐ Fullness or plugged feeling in your ears? Both ears Right ear Left ear

Does it change when you are dizzy? ____

☐ Pain in your ears?	Both ears	Right ear	Left ear
☐ Drainage from your ears?	Both ears	Right ear	Left ear
☐ Distortion of sound?	Both ears	Right ear	Left ear
☐ Abnormal sensitivity to sound?	Both ears	Right ear	Left ear
☐ Feeling of wetness in your ears?	Both ears	Right ear	Left ear
☐ Childhood history of ear infections?	Both ears	Right ear	Left ear
☐ Ear infections as an adult?	Both ears	Right ear	Left ear
☐ History of ear surgery?	Both ears	Right ear	Left ear

☐ History of loud noise exposure? (Firearms, work-related, recreational)

V. Please check (☑) all that apply. Fill in the blank spaces if applicable.

☐ Allergies? ____

☐ Head/neck injuries?

If so, were you unconscious? ____

☐ Tobacco use in any form? How much? ____

☐ Alcohol use? How much? ____

☐ How many cups of coffee, tea, colas or other caffeinated beverages do you drink each day? _______

☐ Eye surgery? ____

☐ Decreased vision? (e.g., cataracts, macular degeneration, glaucoma, retinitis pigmentosa, eye injury, etc.) ____

☐ Weakness or clumsiness in arms and legs?

☐ Diabetes?

☐ Numbness in your feet or legs?

☐ Strokes or TIA's (transient ischemic attacks): _____________________________________

☐ Any other disorders such as Parkinson's disease, multiple sclerosis, myasthenia gravis, seizures, lupus, ALS, Chiari malformation, neurofibromatosis, aneurism, Sjögren's, rheumatoid arthritis, etc.?

☐ Shingles ☐ Shingles in head/neck area? Approximate year: ___________________________

☐ Sudden paralysis of one side of your face (Bell's palsy)? Approximate year: ____________________

☐ Numbness around face/mouth? ☐ Difficulty swallowing? ☐ Difficulty producing speech?

☐ Meningitis or encephalitis?

☐ Hepatitis?

☐ Kidney disease?

☐ High blood pressure? ☐ Heart condition?

☐ Sleep apnea? If so, do you use a CPAP, BiPAP or APAP at night? ____________________

☐ Have you ever had migraine headaches? If so, when did they first start? ____________________

☐ Do visual changes accompany your headaches/migraines?

☐ History of any memorable headaches, or headaches from caffeine withdrawal?

☐ Frequent low-grade headaches? ☐ Any change in the nature of your headaches since the dizziness began?____________________

☐ Early graying of your hair or white patch of hair that was there during childhood or young adulthood?

☐ Panic attacks/hyperventilation? ☐ Anxiety? ☐ Depression? ☐ Post-Traumatic Stress Disorder?

☐ Muscle pain, joint pain or neck or back pain affecting your mobility?____________________

☐ Tingling around mouth?

☐ Childhood history of: ☐ Vertigo? ☐ Dizziness? ☐ Motion sickness?____________________

☐ Claustrophobia? ☐ Extreme fear of the dark?

☐ Have you ever received chemotherapy, radiation, or high doses of antibiotics for a severe infection?

Approximate date(s): ____________________

Treatment area(s):____________________

☐ Have you had balance therapy? If so, when?____________________

Was it helpful to you? ____________________

Have you had any recent imaging studies of your head or neck (e.g., MRI, MRA, X-Rays, CT scans)?

Results if known:____________________

VI. Medications:

Please print (or attach a list) of all the medications, supplements, and over-the-counter products you take and the reason you take it. Please include the dosage (e.g., 25mg, 250mg) and “Route” meaning **how** you take them such as: tablet, capsule, injection, ointment, nasal spray, etc.).

Medication/Supplement/Product	Dosage	Route	Reason you take it

What medications did you take within the last 48 hours? ☐ All of the above.

Otherwise, please specify only those medications you did not take prior to testing:________________

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Over time, my symptoms have:

☐ Gotten worse
☐ Not improved, stayed about the same
☐ Improved somewhat, but still not completely gone
☐ Completely resolved

If you have dizziness, the level of disability from dizziness is best described as:

☐ I can work, drive, and feel no ill effects from my dizziness.

☐ I can continue to function with my dizziness but do not feel well.

☐ I need to stop when dizzy, but then I can return to work or normal activities soon thereafter.

☐ I am totally incapacitated or unable to function normally for extended periods of time because of the dizziness.

☐ I am unable to leave the house.

☐ I am unable to do any daily work.

Does anyone in the family currently have, or is there a family history of:

☐ Migraines ☐ Meniere's disease ☐ Neurological disorder ☐ Anxiety/Depression ☐ Stroke
☐ Hearing loss ☐ Dizziness ☐ Balance problems ☐ Heart disease

Is there any other information you feel would be important for us to know prior to your testing?

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