NewGen Hearing Centers
Dr. Joseph K. Durán

QUESTIONNAIRE

Fill out this form and bring to your appointment:

Last Name: _____ First Name: _____ Middle : _____

Date: ___/___/___ Date of Birth: ___/___/___ Age: ____

1. When you are dizzy, do you experience any of the following sensations?:

- Lightheadedness ☐Yes ☐No
- Swimming Sensation in your head ☐Yes ☐No
- Loss of Consciousness ☐Yes ☐No
- Objects spinning around you ☐Yes ☐No
- Loss of balance while walking ☐Yes ☐No ☐To the Right ☐To the Left
- Tendency to Fall ☐Yes ☐No
- Headaches ☐Yes ☐No

2. Please answer the following questions:

- When did your dizziness first occur? _____
- Is your dizziness constant or does it come and go? _____
  If it comes and goes, how long does it last? _____
  How often? _____
- Do you know any possible cause of your dizziness? _____
- Does anything make your dizziness better or worse? If so, what? _____
  _____
- ¿Is the dizziness provoked by head/body movement? If so, what movement? _____
  _____

3. Please indicate if any of the following are associated with your problem:

- Nausea ☐Yes ☐No
- Vomiting ☐Yes ☐No
- Numbness or weakness in arms, legs or face ☐Yes ☐No
- An increase in sensation with changes in head position ☐Yes ☐No
- A change in vision ☐Yes ☐No
- Falling or loss of balance ☐Yes ☐No
- Trouble walking in the dark ☐Yes ☐No
- Pressure in the head ☐Yes ☐No
- Motion Sickness ☐Yes ☐No
- Tremors ☐Yes ☐No

4. General Medical History. Do you have any of the following?

- Diabetes ☐ Yes ☐ No
- Heart attack ☐ Yes ☐ No
- Stroke ☐ Yes ☐ No
- High blood pressure ☐ Yes ☐ No
- Emotional problems ☐ Yes ☐ No
- Head Injury ☐ Yes ☐ No
- Allergies ☐ Yes ☐ No
- Breathing problems ☐ Yes ☐ No
- Spine or back problems ☐ Yes ☐ No
- Neck problems ☐ Yes ☐ No
- Neurological problems ☐ Yes ☐ No
- Multiple sclerosis ☐ Yes ☐ No
- Epilepsy or seizures ☐ Yes ☐ No
- Arthritis ☐ Yes ☐ No
- Leg or foot problems ☐ Yes ☐ No
- Circulation problems ☐ Yes ☐ No
- Neuropathy ☐ Yes ☐ No

5. Vision History:

☐ Blindness ☐ Glaucoma ☐ Cataracts ☐ Double Vision

- Did you get new glasses recently? _____

6. Ear and Hearing History:

- Do you have difficulty hearing? ☐ Yes ☐ No ☐ Left Ear ☐ Right Ear ☐ Both Ears
- When did you first notice the problem? _____
- Is it getting worse? _____
- Do you have noises in your ears? ☐ Yes ☐ No

  Please describe the noises: _____
- Have you ever had ear surgery? _____
- Do you have pain in your ears? _____
- Do you have drainage from your ears? _____
- Do you have a feeling of pressure in your ears? _____
- Are you sensitive to loud sounds? _____

7. Please write in the space below any other information you feel is important:

_____

_____

_____

_____

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PATIENT INSTRUCTIONS

Electronystagmography (ENG/VNG) Evaluation

You are scheduled for ENG testing on _____ at _____.

Electronystagmography (ENG) is a test performed to evaluate the vestibular system (the balance portion of the inner ear). It will help your doctor determine if this system is contributing to the symptoms of dizziness. The procedure is simple, painless, and requires 1-1.5 hours to complete.

Please arrive 15 minutes early to your appointment, as we will have a detailed questionnaire concerning your symptoms for you to fill out prior to testing.

Certain substances can influence the body's response to this test, reducing its value and validity. **Please DO NOT TAKE any of the following for a period of 24 HOURS prior to your appointment**:

- **Anti-nausea or Anti-vertigo medication** (Antivert, Rubert, Meclizine, etc.)
- **Tranquilizers, Narcotics, Barbiturates, Sedatives or Sleeping Pills**
- **Antihistamines**
- **Alcohol** in any quantity (including beer, wine or any type of medicine containing alcohol)

If you have any questions about your present medications (not listed) please consult your physician.

DO NOT DISCONTINUE HEART MEDICINE, BLOOD PRESSURE MEDICATION, INSULIN, SEIZURE MEDICATION or any medication not described in the list above.

- **No eating, drinking, or smoking for four hours prior to testing** (unless you are diabetic or hypoglycemic)
- **No caffeine** (coffee, tea or cola) after midnight the day before testing.
- **Wear comfortable and loose fitting clothes**.
- **No facial or eye makeup.**

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