



BROWARD ENT CONSULTANTS, PL

5511 N. University Drive, Suite 101B, Coral Springs, FL 33067
Tel. 954-755-4002 • Fax 954-755-5010
www.myentmd.com

Ram K. Madasu, MD, FACS
Otolaryngology – HNS

Victoria Rojas, Au.D, RN
Doctor of Audiology

MRN: _____

CHART No: _____

NAME: _____

DOB: _____

Patient Stamp Above

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 severe 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: _____

