Ordering Physician/PA Todd Berinstein, MD Danielle Brown, PA Kayla Eversole, PA

VERTIGO (Dizziness)

Name: _____ Date: _____

We are interested in your illness and would like to find out more. Please fill this out to the best of your knowledge. If you do not know the exact dates and duration, please estimate.

1. Do you have seasonal or food allergies?

   □No □Yes If yes, please l i s t :

   _____

2. Please write the **first date** you experienced dizziness:_____

3. What did it feel like the first time you were dizzy? **Circle all that apply:**

   Nausea Vomiting Ringing in the Ear(s) Headache Spinning

   Passing out Light Headed Clouded Thoughts Head Fullness Ear Fullness

   a) How long did the first episode last? (1 min, 10 min, 1 hour,1 day, 1 week) _____

   b) Was there any hearing change during the first episode or afterwards?

   □No □Yes If yes, how did it change? _____

4. Please circle how often/ frequently you are experiencing dizziness **NOW:**

   Daily Weekly Every Month Every 6 Months Every Year

5. What is happening to your dizziness? (**circle one**) It is the same It is improving It is worsening

6. Are you able to tell when dizziness is about to happen (are there warning signs)?

   □No □Yes If yes, what is the sign? _____

7. Have you ever had ear surgery?

   □No □Yes If yes, what kind? _____

8. Have you ever had ear infections?

   □No □Yes If yes, when? _____

9. Have you ever had any problems with your eyes?

   □No □Yes If yes, what kind? _____

10. Have you been diagnosed with migraines?

□No □Yes If yes, what kind? _____

11. Have you had any scans (images) of your brain?

□Yes □No If yes, what kind?_____

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Sleep and Snoring Questionnaire

PLEASE ANSWER LEGIBLY TO THE BEST OF YOUR KNOWLEDGE

Name _____ Date _____
Height _____ Weight _____

Do you take sleeping pills? ▫Yes ▫No If yes, what kind? _____
Do you take any kind of medicine that affects your sleep?

▫Yes ▫No If yes, please list _____

Do you have any of the following? (Requiring medication or hospitalization)

High blood pressure	Yes	No	Heart failure	Yes	No
Irregular heart beat	Yes	No	Thyroid disease	Yes	No
Sleep apnea	Yes	No	Heart valve replacement	Yes	No

Please mark any of the following surgeries you have had:

▫Tonsillectomy
▫Adenoidectomy
▫Tracheotomy
▫Uvulopalatoplasty (UVP / UVPP)
▫Nasal surgery
▫Sinus surgery
▫Other oral surgery (list):_____

Please mark problems you are having:

▫Tired all the time
▫Restless or disturbed sleep
▫Night time waking short of breath
▫Excessive movements in sleep
▫Memory problems
▫Nasal congestion / obstruction
▫Stop breathing in sleep
▫Falling asleep during or after meals
▫Recent weight change (+/-_____

▫ Falling asleep while driving
▫ Partner sleeps in another room due to noise.

Have you had a **sleep study**? Yes ▫No If yes, where? _____

Have you had any previous snoring or sleep treatment? ▫Yes ▫No

If yes, please mark:

___ CPAP
___ UPPP
___ Nasal Surgery
___ Tonsillectomy
_____

___ Dental Appliance
___ Maxillary Surgery
___ Pillar
___ Other

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Epworth Sleepiness Scale

Name _____ Date_____
Age (years) _____ Sex: ▫ Male ▫ Female ▫ Other

How likely are you to doze off or fall asleep in the following situations, instead of just feeling tired? This is about your recent and usual way of life.

Even if you have not done some of these things recently, try to think about how they would affect you.

Use the following scale to choose the most appropriate number for each situation:

0	would *never* doze or sleep
1	*slight* chance of dozing or sleeping
2	*moderate* chance of dozing or sleeping
3	*high* chance of dozing or sleeping

It is important that you answer each question as best as you can.

Situation	**Chance of Dozing (0-3)**
Sitting and Reading	_____
Watching TV	_____
Siting, not active, in a public place (movie theatre or a meeting)	_____
Lying down in the afternoon	_____
Being a passenger in a car for an hour without stopping	_____

Sitting and talking to someone _____

Sitting quietly after a lunch (no alcohol) _____

Stopped for a few minutes in traffic while driving _____

Total: _____

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Kayla Eversole, PA-C

SINUSITIS QUESTIONNAIRE

Name _____ Date _____

Please tell us more about your sinuses. Fill this form out to the best of your knowledge, and this will help with your diagnosis and treatment planning.

When was your first sinus infection (sinusitis)?

☐ 1 week ago
☐ 1 month ago
☐ 6 months ago
☐1 year ago
☐5 years ago
☐More than 5 years ago

What are your biggest symptoms (problems) when you have a sinus infection? Please mark ALL that apply:

☐Facial pain ☐Loss of smell ☐Post nasal drip (mucus runs down ☐Stuffiness throat)
☐Other: _____ Foul odor / taste

Which antibiotics have you had in the last 6 months? (Mark ALL that apply):

☐Amoxicillin
☐Azithromycin (Zithromax)
☐Clarithromycin (Biaxin) ☐Ceftin (cefuroxime)
☐Vantin (cefpodoxime)
☐Cleocin (clindamycin)
☐Ciprofloxacin (Cipro)
☐Vibramycin (tetracycl ine)
☐Erythromycin
☐Other: _____

What other treatments have you tried? (Mark ALL that apply):

☐Saline rinse
☐Guaifenisin (Mucinex)
☐ SSKI
☐ Nasal Steroids (Flonase / Nasonex . Omnaris / Nasalide / Vancenase)

Has there been any periods of relief during this illness? □ Yes □ No

If yes, how long? □ 1 week □ 1 month □ 6 months □ 1 year □ 5 years

Have you had a CAT Scan of your sinuses? □ Yes □ No If yes, where and when?

_____