Woodbine DIZZINESS & BALANCE Clinic

Avenue DIZZINESS & BALANCE Clinic

Vertigo Patient's Intake Form 耳水不平衡問卷

Date:			
Name:		OHIP:	
D.O.B.:		Gender:	

Please try to answer all questions. Choose yes or no and fill in the blank spaces.

請盡量回答所有問題, 並選擇最接近的答案及填寫空白處. 請使用英文填寫

What are the reasons for visit? 臨床訪問的原因是什麼?

1. Your dizziness is? 您的頭暈是:

- ☐ Constant 不變的
- ☐ Frequent 頻密的
- ☐ Intermittent 斷斷續續的
- ☐ Regular 規則的
- ☐ Sudden 突然的
- ☐ Unpredictable 不可預知的

a. When did dizziness first occur (very first episode)? 第一次發生頭暈是什麼時候? _____

b. How often do you experience it? 多久一次? _____

c. How long do they last? 每次持續多久? _____

d. When was the last experience? 最後一次是什麼時候? _____

e. Do you have any warning that the dizziness is about to start? 突發前有徵兆嗎? ◯ Yes 有 ◯ No 沒有

f. Do they occur at any particular time of day or night? 有任何特定時間嗎? ◯ Yes 有 ◯ No 沒有

g. Do you feel normal in between dizziness? 兩次頭暈之間是否感覺正常? ◯ Yes 有 ◯ No 沒有

h. Does changing of position make you dizzy? 轉換姿勢時會頭暈嗎? ◯ Yes 有 ◯ No 沒有

2. Do you know of anything that will… 有沒有任何方法可以...

a. Stop your dizziness or make it better? 停止或減少頭暈? ◯ Yes 有 ◯ No 沒有
if yes, please describe: 如果有, 請詳細說明:

b. Make your dizziness worse? 使您的頭暈惡化? ◯ Yes 有 ◯ No 沒有
if yes, please describe: 如果有, 請詳細說明:

c. Triggers your dizziness? 導致頭暈? ◯ Yes 有 ◯ No 沒有
if yes, please describe: 如果有, 請詳細說明:

3. When you are "dizzy" do you experience any of the following sensations?
頭暈的時候, 有沒有遇到以下任何感覺?
Please read the entire list, check the boxes that describe your feelings most accurately.

a. Light headedness or swimming sensation in the head? 頭輕或漂浮的感覺? ◯ Yes 有 ◯ No 沒有

b. Near blacking out or loss of consciousness? 喪失意識? ◯ Yes 有 ◯ No 沒有

c. Tendency to fall? 摔倒的趨勢?
☐ Backward 向後 ☐ Forward 向前 ☐ To the right 向右 ☐ To the left 向左 ☐ No 沒有

d. Objects spinning or turning around you? 物體在您身邊旋轉或轉動? ◯ Yes 有 ◯ No 沒有

e. Sensation that you are spinning inside, with outside objects remaining stationary? 天旋地轉? ◯ Yes ◯ No

f. Loss of balance when walking? 行走時失去平衡? ◯ Yes 有 ◯ No 沒有

g. Headache? 頭痛? ◯ Yes 有 ◯ No 沒有

h. Nausea or vomiting? 作嘔或嘔吐? ◯ Yes 有 ◯ No 沒有

4. Do you have any of the following ear symptoms? 你有沒有下列任何耳部症狀

a. Difficulty in hearing? 聽覺有困難? ◯ No 沒有 ◯ Left ear 左耳 ◯ Right ear 右耳 ◯ Both ears 雙耳

b. Stuffiness or pressure in ears? 耳朵閉塞或壓力?
◯ No 沒有 ◯ Left ear 左耳 ◯ Right ear 右耳 ◯ Both ears 雙耳

c. Pain in ears? 耳痛? ◯ No 沒有 ◯ Left ear 左耳 ◯ Right ear 右耳 ◯ Both ears 雙耳

d. Fluid from ears? 耳朵有液體? ◯ No 沒有 ◯ Left ear 左耳 ◯ Right ear 右耳 ◯ Both ears 雙耳

e. Noise in ears or head? 耳朵或頭部的噪聲?
☐ No 沒有 ☐ Head 頭部 ☐ Left ear 左耳 ☐ Right ear 右耳 ☐ Both ears 雙耳

5. Have you ever experienced any of the following symptoms? 您有沒有經歷任何以下症狀?

a. Double, blurred or loss of vision? 視力模糊或視力喪失?	◯ No 沒有	◯ Constant 經常	◯ Intermittent 斷斷續續
b. Numbness of face, arms or legs? 臉部,手臂或腿部麻木?	◯ No 沒有	◯ Constant 經常	◯ Intermittent 斷斷續續
c. Weakness in arms or legs? 手臂或腿部軟弱?	◯ No 沒有	◯ Constant 經常	◯ Intermittent 斷斷續續
d. Clumsiness in arms or legs? 手臂或腿部遲鈍?	◯ No 沒有	◯ Constant 經常	◯ Intermittent 斷斷續續
e. Confusion or loss of consciousness? 混亂或失去知覺?	◯ No 沒有	◯ Constant 經常	◯ Intermittent 斷斷續續
f. Difficulty with speech? 講話困難?	◯ No 沒有	◯ Constant 經常	◯ Intermittent 斷斷續續
g. Difficulty with swallowing? 吞嚥困難?	◯ No 沒有	◯ Constant 經常	◯ Intermittent 斷斷續續
h. Pain in neck or shoulder? 頸部或肩部疼痛?	◯ No 沒有	◯ Constant 經常	◯ Intermittent 斷斷續續

6. Medical – Social Questions: 醫療 - 社交問題:

a. Do you have low or high blood pressure? 您有沒有低或高血壓?	◯ Yes 有	◯ No 沒有
b. Do you have diabetes? 糖尿病?	◯ Yes 有	◯ No 沒有
c. Do you have low iron levels? 鐵含量低?	◯ Yes 有	◯ No 沒有
d. Do you have low blood count? 血細胞計數低?	◯ Yes 有	◯ No 沒有
e. Do you have a history of stroke? 中風病史?	◯ Yes 有	◯ No 沒有
f. Do you have a history of heart attack? 心臟病發病史?	◯ Yes 有	◯ No 沒有

g. Have you been on any medications to help the dizziness? 您曾經有服用過任何藥物以舒緩頭暈?

◯ Yes 有 ◯ No 沒有

Name of medication: 藥名:

Did they help? 有沒有幫助? ◯ Yes 有 ◯ No 沒有

7. Please check the following that applies: 請選擇以下所有適用的:

- ☐ Previous ear surgery 曾做過耳部手術
- ☐ Previous ear trauma 耳朵曾有創傷
- ☐ Thyroid problems 甲狀腺問題
- ☐ Tobacco in any form 吸煙
- ☐ Trouble with vision 視力障礙

8. Family History: 家人病歷:

- ☐ Hearing loss 聽力損失
- ☐ History of autoimmune diseases 自身免疫性疾病的病歷
- ☐ Vertigo 眩暈

9. Please list all evaluations and/or treatments (Including hearing test, ENG test, MRI, CT scan, etc.) you

have had for your vertigo: 請列出所有做過針對頭暈的評估或治療:

MRI? 磁力共振? ◯ Yes 有 ◯ No 沒有

If you had MRI done, when and where you had it done? What was the evaluation(s)?
如果您做過磁力共振檢查，請列出何時，何處完成檢查？評估结果是什麼？

CT? 電腦掃描? ◯ Yes 有 ◯ No 沒有

If you had CT done, when and where you had it done? What was the evaluation(s)?
如果您做過電腦掃描檢查，請列出何時，何處完成檢查？評估结果是什麼？

ENG? 眼球震顫電流描記法? ◯ Yes 有 ◯ No 沒有

If you had ENG done, when and where you had it done? What was the evaluation(s)?
如果您做過眼球震顫電流描記法檢查，請列出何時，何處完成檢查？評估结果是什麼？

Hearing test? 聽力測試? ◯ Yes 有 ◯ No 沒有

If you had hearing test done, when and where you had it done? What was the evaluation(s)?
如果您做過聽力測試檢查，請列出何時，何處完成檢查？評估结果是什麼？

10. What other medications have you tried in the past for vertigo relief?
(in the following format: Medication? Dose? How often? Does it help? Doctor?)
請列出您曾經服用過的藥物以用作舒緩耳水不平衡: (請用以下格式: 藥物? 劑量? 服用次數? 成效? 醫生?)

11. Please list all other medications you currently take:
(in the following format: Medication? Dose? How often? Length of time taking? Maintenance or short term? Does it help? Doctor?)
請列出您現時服用的藥物: (請用以下格式: 藥物? 劑量? 服用次數? 服用長度? 長期或短期的? 成效? 醫生?)

12. Are you on ODSP or WSIB due to vertigo?
因為耳水不平衡影響, 您現在有否安大略省殘疾支援計劃或職業安全保險?

- [ ] ODSP (Ontario Disability Support Program) 安大略省殘疾支援計劃
- [ ] WSIB (Workplace Safety and Insurance Board) 職業安全保險局
- [ ] None of the above 以上都不是

13. Do you drive and operate heavy machinery? 您現在有否駕駛和操作重型機械?

◯ Yes 有 ◯ No 沒有

14. History of Noise Exposure? 接觸噪聲的病歷?

◯ Yes 有 ◯ No 沒有