



# CENTER FOR BALANCE DISORDERS

http://www.bcm.edu/oto/cfbd  
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## VISIT FORM

The Neurosensory Center of Houston  
3rd Floor, Room NA315

ID Number:

Test Date:

Visit #:

Please Fill in the box below:

Have you been here before?  Yes  No

Name: Last	First	MI	Birthdate: Month	Day	Year
Address: Street			Apt.#		
City		State	Age:		
Telephone: Home: ( )		Zip	Sex:		
Cell: ( )		Height:			
Work: ( )		Weight:			
e-mail Address:		Right or Left Handed:			
		Social Security Number:			

The following information is voluntary.  
Please check the appropriate box(s) concerning your racial/ethnic background.

<input type="checkbox"/>	American Indian or Alaskan Native
<input type="checkbox"/>	Asian, not Vietnamese
<input type="checkbox"/>	Native Hawaiian or Other Pacific Islander
<input type="checkbox"/>	Black or African American
<input type="checkbox"/>	Hispanic or Latino
<input type="checkbox"/>	Vietnamese
<input type="checkbox"/>	White, not of Hispanic Origin
<input type="checkbox"/>	Mixed Race or Ethnicity – Please Indicate:
<input type="checkbox"/>	Other or Unknown

*For CFBD use only:*

Test Battery:

Project:

- Copy of consent form given to subject.  
(Applies to research participants only.)

Physician:

Next Physician's  
Appointment:

Chair to eye distance:

Technician