Allergy Ear Nose & Throat INSTITUTE
EXCELLENCE SINCE 1992
"To God be the Glory"

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Dizziness Questionnaire

Name:		**Date:**
Age:	**Date of Birth:**	**Gender:** **Male / Female**

1) What term(s) best describe your "dizziness?"

- ☐ Spinning sensation – the room / your body
- ☐ Feeling off balance
- ☐ Lightheaded
- ☐ Sensation of falling
- ☐ Nearly passing out
- ☐ Other _____

2) When did your episode **first** occur? _____

☐ How long did it last? _____ Minutes _____ Hours _____Days _____Constant
☐ Has it changed since then?
YES / NO ☐ Stronger ☐ Weaker ☐ More frequent ☐ Less frequent

3) When you try to walk, do you stumble to the ☐ Right or ☐ Left?

4) When was your **last** episode? _____

How often do your episodes occur? ____ Minutes _____ Hours _____ Days
How long does each episode last?
☐ Few seconds ☐ Seconds to minutes ☐ Minutes to hours ☐ Hours to days

5) During your episodes do you experience any of the following:

- ☐ Ear fullness
- ☐ Noise or ringing in your ears
- ☐ Hearing loss
- ☐ Change in hearing
- ☐ Ear pain
- ☐ Memory loss
- ☐ Nausea or vomiting
- ☐ Visual blurring
- ☐ Headaches
- ☐ Falling
- ☐ Double vision
- ☐ Facial numbness
- ☐ Passing out
- ☐ Loss of vision
- ☐ Anxiety attack
- ☐ Difficulty talking
- ☐ Difficulty breathing
- ☐ Other _____

6) What triggers or worsens your dizziness?

- ☐ Standing or sitting up
- ☐ Lying down
- ☐ Nothing triggers it
- ☐ Turning over in bed
- ☐ Head movement
- ☐ Hormonal changes
- ☐ Stress
- ☐ Other _____

7) What makes your dizziness better?

☐ Not moving ☐ Opening my eyes ☐ Eating / Drinking ☐ Medications _____
☐ Other _____ _____

8) Have you changed any medications near the time your dizziness started?

NO / YES _____

9) Have you or are you currently taking any of the following medications for dizziness:

☐ Meclizine / Antivert ☐ Valium ☐ Dyazide / Water pills

Do they help decrease your dizziness? YES / NO

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10) Do you have a history of any of the following: *(if yes, please describe)*

- ☐ Epilepsy / Seizures _____
- ☐ Heart problems _____
- ☐ Migraine Headaches _____
- ☐ Head or Neck injuries _____
- ☐ Loss of Consciousness _____
- ☐ Cancer or Chemotherapy _____
- ☐ IV Antibiotics _____
- ☐ Emotional / Psychiatric problems _____
- ☐ Strokes _____
- ☐ AIDS _____
- ☐ Blood Vessel Narrowing _____
- ☐ Vision Problems _____
- ☐ Ear Infections _____
- ☐ Ear Surgery _____
- ☐ Loss of Bowel or Bladder Control _____
- ☐ Paralysis or Loss of Feeling in the Body _____

11) Do you have a family history of any of the following:

- ☐ Hearing loss
- ☐ Dizziness
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hypoglycemia
- ☐ Asthma
- ☐ Allergies
- ☐ Anxiety disorder

12) Have you had any of the following:

- ☐ Prior evaluation for dizziness _____
- ☐ Evaluation by an ENT Physician _____
- ☐ 24 hour Holter monitor _____
- ☐ Head MRI / CT scan _____
- ☐ Carotid Doppler _____
- ☐ ENG (balance test) _____
- ☐ Hearing Evaluation _____
- ☐ Other _____

13) How would you describe your hearing:

☐ Excellent ☐ Good ☐ Fair ☐ Poor HEARING (Better in RIGHT / LEFT)

14) Do you usually have ear noises (tinnitus)? YES / NO

☐ Right ☐ Left ☐ Both (Worse in RIGHT / LEFT)

EXTRA INFO _____

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