EAR, NOSE AND THROAT ASSOCIATES

Dizziness Questionnaire

Completion of this questionnaire will aid in your diagnosis and treatment. Please ask your doctor if you have trouble answering any questions. Please read the questions first and then circle the answers.

Name _____ Age _____ Date _____

☐ Male ☐ Female Dominant Hand ☐ Right ☐ Left

Address _____ Telephone No. _____

What has been your main occupation in life? _____

SYMPTOM CHECKLIST Circle your **One Main Symptom** and any secondary symptoms

Main *(mark only one)*	**Secondary** *(mark as many as apply)*
☐ A) Dizzy with a clear sensation of spinning	☐
☐ B) Dizzy with non-spinning sensation of movement	☐
☐ C) Dizzy without sensation of movement	☐
☐ D) A feeling of lightheadedness	☐
☐ E) Tendency to lose balance or fall	☐
☐ F) Feeling about to faint	☐
☐ G) Nausea or vomiting	☐
☐ H) Tingling of hands or feet	☐
☐ I) Shortness of breath	☐
☐ J) Disorientation or confusion	☐
☐ K) Pain behind eyes on urination	☐
☐ L) Difficulty walking	☐
☐ M) Neck stiffness or pain	☐
☐ N) Hearing loss	☐
☐ O) Headache	☐
☐ P) Memory Loss	☐

Other symptoms

_____

_____

_____

When did your symptoms begin? _____

Did your symptoms come on suddenly? ☐ Yes ☐ No

Did your symptoms come in attacks? ☐ Yes ☐ No

If your symptoms come in attacks, how long does a typical attack last? _____

When was your last attack? _____

How often do they occur? _____

Do they occur at any particular time of day? ☐ Yes ☐ No

If yes, when _____

Are there other symptoms associated with attacks? ☐ Yes ☐ No

If so what are they? _____

Are you completely symptom free between attacks? ☐ Yes ☐ No

If your symptoms are constant, is there a time of day when most affected? _____

Least affected? _____

Were you suffering from another disease or infection at the time your symptoms came on? ☐ Yes ☐ No

If yes, what? _____

Do your symptoms occur only in certain body or head positions? ☐ Yes ☐ No

If yes, what are they? _____

Do your symptoms occur only when changing positions such as turning in bed? ☐ Yes ☐ No

If yes, which change most reliably brings it on? _____

Do you know of anything that will make your symptoms better? _____

or worse ? _____

or brings on an attack? _____

Does coughing, sneezing or blowing your nose usually bring on your symptoms? ☐ Yes ☐ No

Does a change in altitude usually bring on your symptoms? ☐ Yes ☐ No

Have you ever seriously injured your head or neck? ☐ Yes ☐ No

If so, when? _____

Was this related to your symptoms? ☐ Yes ☐ No

If so, how? _____

Do you smoke or chew tobacco? ☐ Yes ☐ No

If yes, how much? _____

Do you drink alcoholic beverages? ☐ Yes ☐ No

If so, how much on average? _____

Do you have a history of susceptibility to motion sickness? ☐ Yes ☐ No

Do you experience migraine (sick) headaches? ☐ Yes ☐ No

Do you have a family history of migraine headaches? ☐ Yes ☐ No

If so, in whom? _____

Please list any major medical problems and their dates of onset _____

_____

Please list all medications you are currently taking and circle any you feel may be causing your symptoms _____

_____

Please list any treatment you have been given for your symptoms and circle any that have helped _____

_____

Has anyone in your family ever had a problem with imbalance or dizziness? ☐ Yes ☐ No

If so, who and when? _____

Do you have a family history of any neurological diseases? ☐ Yes ☐ No

If so, what? _____

Do you know of any possible cause of your symptoms? ☐ Yes ☐ No

What? _____

PLEASE CHECK THE APPROPRIATE LINE IF YOU HAVE ANY OF THE FOLLOWING

	Right Ear	Left Ear	Both Ears
Difficulty in hearing	☐	☐	☐
Hearing distortion	☐	☐	☐
Noises in ear	☐	☐	☐
Ear fullness or pressure	☐	☐	☐
Pain in ear	☐	☐	☐
Discharge from ear	☐	☐	☐

	With Symptoms	Without Symptoms
Doubled vision	☐	☐
Blurred vision	☐	☐
Oscillating (wiggling) vision	☐	☐
Tingling around mouth or face	☐	☐
Numbness of feet or hand	☐	☐
Weakness of arms or legs	☐	☐
Nausea or vomiting	☐	☐
Headache	☐	☐
Pain in neck or shoulder	☐	☐
Clumsiness of arms or legs	☐	☐
Confusion	☐	☐
Loss of consciousness	☐	☐
Difficulty with speech	☐	☐
Difficulty with swallowing	☐	☐
Convulsion or seizures	☐	☐
Palpitations or chest pain	☐	☐
Shortness of breath	☐	☐

Please estimate your current level of life stress on a scale of 1-10 (10 being the greatest) _____

Do you exercise regularly? ☐ Yes ☐ No

If yes, what type? _____

Were you in the military service? ☐ Yes ☐ No

Branch _____ Years _____ Artillery or noise exposure? _____

Have you ever been given ototoxic antibiotics? ☐ Yes ☐ No

Please check ☐ Neomycin ☐ Streptomycin ☐ Kanamycin ☐ Gentamicin

Do you have any other noise exposures? ☐ Yes ☐ No

Where and what? _____

Any other comments concerning your symptoms or health? _____

_____

_____

_____

_____

_____