MOUNTAIN HOME ENT & ALLERGY
DIZZINESS QUESTIONNAIRE

PATIENT'S NAME: ______________________________

BIRTH DATE: ____________________

1. When you are "dizzy" do you experience any of the following sensations?
Please read the entire list first. Check YES or NO to describe your feelings most accurately.

YES NO

1. Lightheadedness or swimming sensation in the head
2. Blacking out or loss of consciousness
3. Tendency to fall: To the right?
   To the left?
   Forward?
   Backward?
4. Objects spinning or turning around you.
5. Sensation that you are turning or spinning inside, with outside objects remaining stationary
6. Loss of balance when walking: Veering to the right?
   Veering to the left?
7. Headache
8. Nausea or vomiting
9. Pressure in the head

2. Please check YES or NO and fill in the blank spaces. ***Answer all Questions***

YES NO

1. My dizziness is: Constant?
   In attacks?
2. When did dizziness first occur? ____________________
3. If in attacks: How often? ____________________
   How long do they last? ____________________
   When was the last attack? ____________________
   Do you have any warning that the attack is about to start?
   Do they occur at any particular time of day or night?
   Are you completely free of dizziness between attacks?
4. Does change in position make you dizzy?
5. Do you have trouble walking in the dark?
6. When you are dizzy, must you support yourself when standing?
7. Do you know of any possible cause of your dizziness?
   What? ______________________________

DATE: ____________________ **CHART NUMBER:** ____________________

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8. Do you know of anything that will:
   Stop your dizziness or make it better? ____________________
   Make your dizziness worse? ____________________
   Precipitate an attack? (Fatigue? Exertion? Hunger? Menstrual Period? Stress? Emotional Upset?)
9. Were you exposed to any irritating fumes, paints, etc., at the onset of dizziness?
10. If you are allergic to any medications, please list: ____________________

____
11. If you ever injured your head, were you unconscious?
12. If you take any medications regularly, for any reason, please list: ____________________

____
13. Do you use tobacco in any form? How much? ____________________

3. Do you have any of the following symptoms?

PLEASE MARK YES OR NO ***MARK EAR INVOLVED***

YES	NO	Symptom			
		1. Difficulty in hearing?	Both Ears	Right	Left
		2. Noise in your ears?	Both Ears	Right	Left

Describe the noise: ____________________

Does noise change with dizziness? If so, how? ____________________

____

YES	NO	Symptom			
		3. Fullness or stuffiness in your ears?	Both Ears	Right	Left
		4. Pain in your ears?	Both Ears	Right	Left
		5. Discharge from your ears?	Both Ears	Right	Left

4. Have you experienced any of the following symptoms?

PLEASE MARK YES OR NO ***MARK ONE***

YES	NO	Symptom		
		1. Double vision, blurred vision or blindness	Constant	In Episodes
		2. Numbness of face	Constant	In Episodes
		3. Numbness of arms or legs	Constant	In Episodes
		4. Weakness in arms or legs	Constant	In Episodes
		5. Clumsiness of arms or legs	Constant	In Episodes
		6. Confusion or loss of consciousness	Constant	In Episodes
		7. Difficulty with speech	Constant	In Episodes
		8. Difficulty with swallowing	Constant	In Episodes
		9. Pain in the neck or shoulder	Constant	In Episodes