Advanced Hearing Center

1223 Lake Pointe Pkwy
Sugar Land, Texas 77478

Dizziness Questionnaire

Name: _____ Date: _____

1. Do you have dizziness or imbalance? □Yes □No
If yes, when did the dizziness or imbalance first occur? _____

2. Does it occur when you are standing or walking? □Yes □No

3. How often do you become dizzy or imbalanced? _____

4. Do your symptoms occur in spells? □Yes □No
If yes:
a. How long does the spell last?_____
b. When did you have your last spell? _____
c. Do you have dizziness between spells? □Yes □No
d. Is the onset of dizziness sudden or gradual? _____
e. How often do you have these spells? _____

5. If you change positions does it make you dizzy or off balance? □Yes □No
Are your symptoms made worse by any of the following? (Check all that apply)

Lying down/turning over in bed
Walking in the dark
Hot baths or showers
Menstrual cycle
Riding in a car
Loud sounds
Reading
Exercise
Lifting things
Sitting up/Standing up
Walking on uneven surfaces
Coughing or sneezing
Walking in supermarket aisles
Looking up
Turning head while walking

6. Did you take a long trip before the dizziness or imbalance began?
If yes, please describe: _____

7. Do you know anything that makes your dizziness or imbalance
better: _____
worse: _____

8. Have you ever had ear surgery? Yes No
   a. What procedure?_____
   b. When? _____

9. Have you ever had surgery on you head or neck area? Yes No
   a. What procedure?_____
   b. When? _____

10. Are you currently taking any medications or over the counter remedies?
    _____
    _____

11. Did you take any medications within the last 24 hours? If so, please list them.
    _____
    _____

12. Do you drink alcohol? Yes No
    a. How often do you consume alcoholic beverages_____
    b. When was your last alcoholic drink_____
    c. How often do you consume caffeine (coffee, tea, cola and chocolate)?
       _____
    d. How often do you smoke or chew tobacco?_____
    e. When was the last time you smoked cigarettes, cigars, pipe or chewed tobacco? _____