Rocky Mountain Ear, Nose and Throat
200 West County Line Road, Suite 330, Highlands Ranch, CO 80129
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Patient Name: ______________________________ **Date:** __________

Patient Vertigo Questionnaire

(Please answer each question by checking the box which best describes your experience accurately.)

Section I - When you experience being 'dizzy' do you have any of the following sensations?

1. Light headedness or swimming sensation in your head. Yes ☐ No ☐
2. Blacking out or loss of consciousness. Yes ☐ No ☐
3. Tendency to fall:
   - To the right. Yes ☐ No ☐
   - To the left. Yes ☐ No ☐
   - Forward. Yes ☐ No ☐
   - Backward. Yes ☐ No ☐
4. Objects spinning or turning around you. Yes ☐ No ☐
5. Sensation that you are turning or spinning inside, with outside objects remaining stationary. Yes ☐ No ☐
6. Loss of balance when walking:
   - To the right. Yes ☐ No ☐
   - To the left. Yes ☐ No ☐
7. Headache. Yes ☐ No ☐
8. Nausea or vomiting. Yes ☐ No ☐
9. Pressure in the head. Yes ☐ No ☐

(Please answer each question by checking the box which best describes your experience accurately or filling in blank spaces when asked.)

Section II - Describing your dizziness.

1. When did your dizziness first occur? ______________
2. My dizziness is:
   - Constant. Yes ☐ No ☐
   - Intermittent attacks. Yes ☐ No ☐

If you answered Intermittent attacks:
- How often. ______________
- How long. ______________
- Date of last attack. ______________
- Warning that attack will start. Yes ☐ No ☐
  Describe: ______________
- Specific time of day/night Night ☐ Day ☐ Both ☐
- Free of dizziness between attacks. Yes ☐ No ☐

(Please check the appropriate box for each symptom and circle which ear is involved.)

Section III - Symptom descriptions.

1. Difficulty in hearing? Yes ☐ No ☐
   Both ears
   Right ear only
   Left ear only

2. Noise in your ear(s)? Yes ☐ No ☐
   Both ears
   Right ear only
   Left ear only
   Noise description:
   ____
   ____

3. Fullness or stuffiness in your ears? Yes ☐ No ☐
   Both ears
   Right ear only
   Left ear only

4. Pain in your ears? Yes ☐ No ☐
   Both ears
   Right ear only
   Left ear only

5. Discharge from ears? Yes ☐ No ☐
   Both ears
   Right ear only
   Left ear only

(Please check the appropriate box for each symptom and circle if Constant or Episodes.)

Section IV - Symptom descriptions.

1. Double vision, blurred vision or blindness: Yes ☐ No ☐
   Constant
   Episodes

2. Numbness of face or extremities: Yes ☐ No ☐
   Constant
   Episodes

3. Weakness in arms and legs? Yes ☐ No ☐
   Constant
   Episodes

4. Clumsiness in arms or legs? Yes ☐ No ☐
   Constant
   Episodes

Section II - (Continued)

3. Does a change of position make you dizzy? Yes ☐ No ☐

4. Do you have trouble walking in the dark? Yes ☐ No ☐

5. Must you support yourself when dizzy? Yes ☐ No ☐

6. Do you know of any possible causes for your dizziness? Yes ☐ No ☐
   Describe if Yes: ______________________
   ____
   ____

7. What will:
   Stop your dizziness. ______________________
   Make it better. ______________________
   Make it worse. ______________________

8. Will any of the following start an attack.

Fatigue.	Yes ☐	No ☐
Exertion.	Yes ☐	No ☐
Hunger.	Yes ☐	No ☐
Menstrual period.	Yes ☐	No ☐
Stress.	Yes ☐	No ☐
Emotional upset.	Yes ☐	No ☐

9. Were you exposed to any irritation fumes, paints, etc., at the the onset of dizziness? Yes ☐ No ☐

10. Do you have any allergies? Yes ☐ No ☐
    If Yes, please list: ______________________
    ____
    ____
    ____

11. Have you ever sustained an injury to your head? Yes ☐ No ☐
    If Yes, were you unconscious? Yes ☐ No ☐

12. Do you take medications regularly? Yes ☐ No ☐
    If Yes, please list: ______________________
    ____
    ____
    ____
    ____
    ____

13. Do you use tobacco, in any form? Yes ☐ No ☐
    If Yes, how much: ______________________
    ____
    ____

Section IV - (Continued)

5. Confusion or loss of consciousness? Yes ☐ No ☐
   Constant
   Episodes

6. Difficulty with speech? Yes ☐ No ☐
   Constant
   Episodes

7. Difficulty with swallowing? Yes ☐ No ☐
   Constant
   Episodes

8. Pain in the neck or shoulder? Yes ☐ No ☐
   Constant
   Episodes

Thank you for your time and patience in completing this questionnaire.