Stark ENT

DIZZINESS HISTORY QUESTIONAIRE

NAME_____AGE_____DATE_____

WHEN was the **first** time you ever had dizziness?

_____

_____

WHAT were the circumstances? _____

WHEN was the last time you experienced dizziness? _____

WHAT were the circumstances?_____

CURRENTLY, MY DIZZINESS

- ◯IS CONSTANT
- ◯IS ALWAYS THERE BUT CHANGES IN INTENSITY
- ◯COMES IN EPISODES

IF IT COMES AND GOES:

How long does it typically last? ____seconds / minutes/ hours (Circle ONE)

How often does it typically occur? _____times per: hour / day / week / month / year

MY DIZZINESS MOSTLY CONSISTS OF (check ALL that apply)

- ◯ Spells of spinning with nausea
- ◯ off-balance sensation
- ◯ other, Please explain _____

BETWEEN EPISODES I FEEL: (Check ALL that apply)

- ◯ dizzy or off balance all the time
- ◯ normal
- ◯ other, Please explain _____

MY EPISODES OCCUR (check ALL apply)

- ◯ Spontaneously. Nothing I do seems to bring them on or turn them off
- ◯ only when standing or walking
- ◯ in relation to any head motion
- ◯ only I certain head positions. Please describe _____

WHEN I ROLL OVER IN BED (check ONE)

- ◯ nothing unusual happens
- ◯ the room seems to spin sometimes

IS THERE ANYTHING THAT YOU CAN DO TO MAKE YOUR DIZZINESS GO AWAY?

(sit, lay down close eyes, …)

Please explain_____

_____

CIRCLE ALL THAT APPLY

I have hearing difficulty *Right / Left / Both*

I have ringing or other sounds *Right / Left / Both*

I have ear fullness *Right / Left / Both*

I have had ear surgery *Right / Left / Both*

Circle yes or no

- Did you have cold, flu or virus type symptoms shortly before the onset of your dizziness ? YES / NO
- Did you cough, lift, sneeze, fly in a plane, swim under water or have a head trauma shortly before the onset of your dizziness? YES / NO
- Were you exposed to any irritating fumes, paints, etc. at the onset of your dizziness? YES / NO
- Do you get dizzy when you have not eaten for a long time? YES / NO
- Is your dizziness connected with your menstrual period? YES / NO
- Did you get new glasses or have cataract surgery recently YES / NO
- I consider myself to be an anxious or tense person YES / NO

IN THE PAST YEAR I HAVE HAD (CHECK ALL THAT APPLY)

◯ loss of consciousness ◯ occasional loss of vision ◯ seizures or convulsions

◯ Severe pounding headache or migraine ◯ slurring of speech ◯ difficulty swallowing

◯ Palpitations of the heartbeat ◯ weakness in one hand, arm or leg ◯ tingling around mouth

◯ Double vision ◯ tendency to fall ◯ spots before the eyes ◯ loss of balance when walking

I HAVE OR HAVE HAD (CHECK ALL THAT APPLY)

◯ Diabetes ◯ Stroke ◯ Migraine Headaches ◯ Arthritis

◯ A neck and or back injury ◯ Irregular heartbeat ◯ Allergies

PLEASE CHECK BELOW FOR ANY MEDICATIONS YOU HAVE TRIED FOR DIZZINESS OR ARE CURRENTLY TAKING

| | TAKEN IN PAST | TAKING NOW | HELPS |
|---|---|---|---|
| Antivert | _____ | __ _____ | _____ |
| Valium | _____ | _____ | _____ |
| Dyazide | | | |

HAVE YOU EVER BEEN PREVIOUSLY EVALUATED FOR DIZZINESS?

Where and When?

_____

_____