THE DIZZINESS QUESTIONNAIRE

Name: ___________________________ Date of exam: ___________________________
DOB: ___________________________ Age: _________ Referring Doctor: ___________________________

Please answer these questions to the best of your ability
Please describe the problems with your dizziness and balance:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

When did the dizziness first occur? _____________________________________________
Is the dizziness constant or does it come in episodes? _____________________________
If the dizziness occurs in episodes, how often do they occur? __________ times per day / week / month / year
How long do the episodes last? ☐ Seconds ☐ Minutes ☐ Hours ☐ Days
Since the first episode, are they becoming? ☐ more frequent ☐ less frequent ☐ the same
Are you having any symptoms now? ____________________________________________
Does anything make your dizziness better? _______________________________________

Please check the following that increase/provoke your dizziness:
☐ Change in weather ☐ Change body positions ☐ Looking up/down
☐ Walking in the dark ☐ Walking up/down stairs ☐ Riding in elevators
☐ Walking around corners ☐ Walking in shopping malls ☐ Head movements
☐ Loud noises ☐ Stress ☐ Other:___________

Please check the following that bother you when dizzy:
☐ Riding through tunnels ☐ Ladders/heights ☐ Driving/riding in a car
☐ Riding in an airplane ☐ Riding in a boat ☐ Reading in a car

If you have an earache, are you also dizzy at that time? ☐ Yes ☐ No
Do you think your dizziness is related to menstrual periods/menopause? ☐ Yes ☐ No ☐ N/A
Is your dizziness worse when you are tired? ☐ Yes ☐ No
Have you experienced sudden falls while standing/walking? ☐ Yes ☐ No
Would you describe your gait as steady? ☐ Yes ☐ No

When you are dizzy do you experience any of the following? Check as many as needed
☐ Nausea/vomiting ☐ Migraine/headache
☐ Loss of consciousness ☐ Tendency to fall (right or left)
☐ Loss of balance ☐ Lightheadedness
☐ Other, please specify ____________________________________________________________
EAR AND HEARING HISTORY

Do you think you have hearing loss? ☐ Yes ☐ No
If yes, which ear(s)? __________________________
Was the loss sudden or gradual? __________________________

Do you feel your hearing fluctuates with dizziness? ☐ Yes ☐ No
Have you experienced loud noise exposure? ☐ Yes ☐ No
Do you experience tinnitus? ☐ Yes ☐ No
If yes, please describe the sound: __________________________

Do you have pressure/fullness in your ears? ☐ Yes ☐ No
If yes, which ear(s)? __________________________

Do you have numbness/tingling in your ears? ☐ Yes ☐ No
If yes, which ear(s)? __________________________

Do you experience chronic ear infections? ☐ Yes ☐ No
If yes, when was the last one? __________________________

Are you aware of a perforated ear drum? ☐ Yes ☐ No
If yes, which ear(s)? __________________________

Have you had any ear surgeries? ☐ Yes ☐ No
If yes, please describe: __________________________

LIFESTYLE

Do you drink alcohol? ☐ Yes ☐ No
If yes, how many drinks per day? __________________________

Do you smoke? ☐ Yes ☐ No
If yes, how many cigarettes per day? __________________________

Have you smoked in the past? ☐ Yes ☐ No
When did you quit? __________________________

Do you consume caffeinated beverages? ☐ Yes ☐ No
If yes, how many of the following?
☐ Cups of coffee ______  ☐ Cups of cocoa ______
☐ Cups of tea ______  ☐ Cola drinks ______

Do you consume a lot of sugar? ☐ Yes ☐ No
Do you consume excessive salt? ☐ Yes ☐ No
Do you feel you have insomnia? ☐ Yes ☐ No
How many hours of sleep do you get per night? __________________________

Do you exercise? ☐ Yes ☐ No
If yes, how often per week __________________________
What type of exercise? __________________________

Please list all your current medications, including hormones, birth controls, vitamins, etc.

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<thead>
<tr>
<th>Name</th>
<th>Dosage</th>
<th>Amount per day</th>
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What medications have been taken for dizziness?

<table>
<thead>
<tr>
<th>Do it help?</th>
<th>☐ Yes ☐ No</th>
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<tr>
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<td>☐ Yes ☐ No</td>
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<td>☐ Yes ☐ No</td>
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Please list any allergies to medications:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Please check those items you have experienced and dates:

☐ Low back pain __________☐ Neck pain __________☐ Foot problems __________
☐ Loss if feeling in feet/legs ______☐ Neck injury ______☐ Whiplash ______
☐ Ankle sprain/fracture __________☐ Knee injury ______☐ Hip Injury ______
☐ Loss of consciousness __________☐ Head injury ______☐ Concussion ______
☐ Irregular heart beat __________☐ Diabetes __________☐ Eye problem ______
☐ Headaches/migraines __________☐ Cataracts __________☐ Loss of vision ______
☐ Low blood sugar __________☐ High cholesterol ______☐ Heart attack ______
☐ Cardiac surgery __________☐ TMJ __________☐ Jaw pain ______
☐ Recent dental work __________☐ Arthritis __________☐ Stroke ______
☐ Treatment by a psychiatrist _____☐ Convulsion ______☐ Depression ______
☐ Unusual stress ______☐ Panic attacks ______☐ Seizure ______
☐ Treatment by a psychologist _____☐ Chemotherapy ______☐ Other ______

Have you had any of the following? Check all that apply:

☐ Mononucleosis ☐ Insect bites ☐ Tick bites ☐ Mumps
☐ Exposure to HIV ☐ Measles ☐ Meningitis ☐ Syphilis
☐ Veneral Disease ☐ Exposure to AIDS ☐ Epstein Barr ☐ Polio
☐ Blood transfusion in the last 5 years

Check all that apply. Please include the date of test, where the test was performed and the results of the testing:

☐ Hearing test __________________☐ ENG (Electronystagmography) __________
☐ EEG __________________☐ CT Scan of brain __________________
☐ EKG __________________☐ CT Scan of ears __________________
☐ Rotary Chair Test __________________☐ OAE (Otoacoustic Emissions) __________
☐ Neck X-rays __________________☐ V.A.T. (Vestibular Autorotation Test) __________
☐ ECOG (Electrocochleography) __________________☐ Balance Platform Test (Posturography) __________
☐ Complete Physical __________________☐ Neurology Evaluation
cell
☐ Holter monitor testing __________________☐ Lumbar Puncture (Spinal Fluid Study) __________
☐ MRA __________________☐ Carotid artery doppler flow study __________
☐ BAER / ABR (brainstem auditory evoked response /auditory brainstem response) __________________
☐ MRI of brain __________☐ with contrast ☐ without contrast
☐ MRI of ears __________☐ with contrast ☐ without contrast

Please list any additional comments:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________