EAR·NOSE·THROAT SPECIALISTS
of Northern Virginia, P.C.

PROFESSIONAL HEARING SERVICES
The Dizziness and Balance Center
The Hearing Aid Center

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/provokes 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 ______________________________

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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.

Name	Dosage	Amount per day

What medications have been taken for dizziness?

	Did it help?	☐ Yes	☐ No
	Did it help?	☐ Yes	☐ No

Please list any allergies to medications:

____
____
____
____

Please check those items you have experienced and dates:

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

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

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

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

- ☐ Hearing test ____________
- ☐ EEG____________
- ☐ EKG____________
- ☐ Rotary Chair Test ____________
- ☐ Neck X-rays ____________
- ☐ ECOG (Electrocochleography) ____________
- ☐ Complete Physical ____________
- ☐ Holter monitor testing ____________
- ☐ MRA ____________
- ☐ ENG (Electronystagmography) ____________
- ☐ CT Scan of brain ____________
- ☐ CT Scan of ears ____________
- ☐ OAE (Otoacoustic Emissions) ____________
- ☐ V.A.T. (Vestibular Autorotation Test) ____________
- ☐ Balance Platform Test (Posturography) ____________
- ☐ Neurology Evaluation ____________
- ☐ Lumbar Puncture (Spinal Fluid Study) ____________
- ☐ 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:

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