

**EAR, NOSE THROAT ASSOCIATES OF MOUNTAIN HOME
DIZZINESS QUESTIONNAIRE**

PATIENT'S NAME: _____

BIRTH DATE: _____

1. When you are "dizzy" do you experience any of the following sensations?

Please read the entire list first. Circle YES or NO to describe your feelings most accurately.

- YES NO** 1. Lightheadedness or swimming sensation in the 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: Veering to the right?
YES NO Veering to the left?
YES NO 7. Headache
YES NO 8. Nausea or vomiting
YES NO 9. Pressure in the head

2. Please circle YES or NO and fill in the blank spaces. Answer all Questions

- YES NO** 1. My dizziness is: Constant?
YES NO In attacks?
2. When did dizziness first occur? _____
3. If in attacks: How often? _____
How long do they last? _____
When was the last attack? _____
- YES NO** Do you have any warning that the attack is about to start?
YES NO Do they occur at any particular time of day or night?
YES NO Are you completely free of dizziness between attacks?
YES NO 4. Does change in position make you dizzy?
YES NO 5. Do you have trouble walking in the dark?
YES NO 6. When you are dizzy, must you support yourself when standing?
YES NO 7. Do you know of any possible cause of your dizziness?
What? _____

DATE: _____

CHART NUMBER: _____

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8. Do you know of anything that will:

YES NO Stop your dizziness or make it better? _____

YES NO Make your dizziness worse? _____

YES NO Precipitate an attack? (Fatigue? Exertion? Hunger? Menstrual Period? Stress? Emotional Upset?) _____

YES NO 9. Were you exposed to any irritating fumes, paints, etc., at the onset of dizziness?

YES NO 10. If you are allergic to any medications, please list: _____

YES NO 11. If you ever injured your head, were you unconscious? _____

12. If you take any medications regularly, for any reason, please list: _____

YES NO 13. Do you use tobacco in any form? How much? _____

3. Do you have any of the following symptoms?

PLEASE CIRCLE **YES** **OR** **NO**

CIRCLE EAR INVOLVED

YES NO 1. Difficulty in hearing? Both Ears Right Left

YES NO 2. Noise in your ears? Both Ears Right Left

Describe the noise: _____

YES NO Does noise change with dizziness? If so, how? _____

YES NO 3. Fullness or stuffiness in your ears? Both Ears Right Left

YES NO 4. Pain in your ears? Both Ears Right Left

YES NO 5. Discharge from your ears? Both Ears Right Left

4. Have you experienced any of the following symptoms?

PLEASE CIRCLE **YES** **OR** **NO**

CIRCLE ONE

YES NO 1. Double vision, blurred vision or blindness Constant In Episodes

YES NO 2. Numbness of face Constant In Episodes

YES NO 3. Numbness of arms or legs Constant In Episodes

YES NO 4. Weakness in arms or legs Constant In Episodes

YES NO 5. Clumsiness of arms or legs Constant In Episodes

YES NO 6. Confusion or loss of consciousness Constant In Episodes

YES NO 7. Difficulty with speech Constant In Episodes

YES NO 8. Difficulty with swallowing Constant In Episodes

YES NO 9. Pain in the neck or shoulder Constant In Episodes