ENT Ear, Nose & Throat Specialty Care

Administrative Office: 2211 Park Avenue South | Minneapolis, Minnesota 55404 | Tel. 612.871.1144 | Fax 612.871.2012

Dizziness Questionnaire

Patient Name: _____ Date of Birth: _____ Date: _____

Please answer the following questions by circling YES or NO and filling in the blank.

1) When did your dizziness first begin? _____

2) Is the dizziness constant? YES NO

If the dizziness is not constant (episodic)

How often? _____ How long does it last? _____

3) Do you experience:

a. Light headedness? YES NO

b. Swimming sensation in the head? YES NO

c. Black-out spells? YES NO

d. Loss of consciousness? YES NO

e. Objects spinning or turning about you? YES NO

f. Sensation that you are spinning or turning, and that outside objects remain stationary? YES NO

g. Loss of balance when walking? YES NO

If yes, do you veer to the RIGHT ____ or LEFT ____

4) Do changes in position make you dizzy? YES NO

5) Are you dizzy when looking up, such as getting something from the top shelf? YES NO

6) Are you free of dizziness between episodes? YES NO

7) Do you have headaches with the dizziness? YES NO

8) Do you get nauseated when you are dizzy? YES NO

9) Do you vomit when you are dizzy? YES NO

10) Do you have trouble walking in the dark? YES NO

11) Will anything stop your dizziness or make it better? YES NO

Explain: _____

12) Will anything make your dizziness worse?

Explain: _____

13) Will anything bring on the dizziness?

Explain: _____

14) Can you tell when the dizziness is about to start?

Explain: _____

15) Do you have discharge from your ears? No ____ Both ears ____ Right ____ Left _____

16) Do you have difficulty hearing? No ____ Both ears ____ Right ____ Left _____

17) Does your hearing get worse with the dizziness? No ____ Both ears ____ Right ____ Left _____

18) Do you have noise in your ears? No ____ Both ears ____ Right ____ Left _____

Describe the noise: _____

19) Do you have noise in your ears that changes with the dizziness? YES NO

If yes how? _____

20) Do you have fullness or blocked feeling in the ears? No ____ Both ears ____ Right ____ Left _____

21) Do you have pain in your ears? No ____ Both ears ____ Right ____ Left _____

22) Have you ever injured your head? YES NO

If yes, did the injury cause you to become unconscious? YES NO

23) Do you take any medication for dizziness?

List: _____

24) Do you have or have you had:

_____ Heart trouble _____ High blood pressure _____ Anxiety/panic attacks

_____ Stroke _____ Diabetes _____ Kidney disease

_____Thyroid disease _____ Migraines

Do you experience any of the following symptoms, circle either CONSTANT or IN EPISODES:

Headache	CONSTANT	IN EPISODES
Pressure in head	CONSTANT	IN EPISODES
Double vision	CONSTANT	IN EPISODES
Numbness/tingling in face or extremities	CONSTANT	IN EPISODES
Blindness or flashing lights	CONSTANT	IN EPISODES
Weakness in arms or legs	CONSTANT	IN EPISODES
Clumsiness in arms or legs	CONSTANT	IN EPISODES
Confusion or loss of consciousness	CONSTANT	IN EPISODES
Difficulty with speech	CONSTANT	IN EPISODES
Difficulty with swallowing	CONSTANT	IN EPISODES