

**Ear, Nose and Throat Center of the Ozarks
601 West Maple Ave, Suite 213
Springdale, AR 72764
(479) 750-2080**

Dizziness Questionnaire

Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Date of Birth: _____

Referring Physician: _____

.....

Describe your symptoms without using the word dizzy or vertigo: _____

How long have symptoms been present: _____

Was onset Gradual Sudden

Is dizziness..... All the time (constant) Comes and goes(episodic)

If episodic how often does symptoms occur: _____

How long does a typical episode last: Seconds Minutes Hours Days

Is an episode ever triggered by anything specific? Yes No

If yes, explain: _____

Do episodes ever occur when you are moving? Yes No

Do you have car/boat/airplane sickness? Yes No

Do episodes causes changes in your hearing, unusual ringing/roaring sounds or pressure in your head/ears? Yes No

If yes, please explain: _____

Does motion or movement make symptoms worse? Yes No

If yes explain which types of activities or movements: _____

Do you become nauseated with symptoms? Yes No

If female, is your dizziness associated with your menstrual cycle? Yes No N/A

Have you ever blacked out or fainted while having an episode? Yes No

How many times? _____

Have you ever fallen? Yes No How often? _____

During an episode do you have problems with speaking? Yes No

During an episode have you ever experienced arm or leg weakness? Yes No

Do you have high blood pressure? Yes No

If yes, is it controlled by medication? _____

Do you have a history of the following?

Stroke Heart disease Heart Surgery

Have you ever had a severe head injury with a loss of consciousness or skull fracture ?

Yes No

If yes, please explain: _____

When having an episode which of the following best describes your symptoms:

Lightheadedness Unsteadiness(imbalance) Sensation of spinning/moving

Do you have problems walking on uneven surfaces? Yes No

Does darkness or closing your eyes seem to make your symptoms worse? Yes No

Do you have problems watching objects moving in your environment (train going by, traffic, sunlight through trees)? Yes No

Does coughing, laughing, sneezing or straining seem to make symptoms worse or occur?
Yes No

Do you have problems with symptoms while driving? Yes No
If so, explain: _____

HEADACHES

Do you have headaches? Yes No
If yes, how often: _____

Do you have a history of migraine headaches? Yes No
If yes, do they seem to be related or effect dizziness? Yes No

Does anyone in your family have a history of migraine headaches? Yes No

Do you have a change in your vision during episodes? Yes No
If yes, please explain: _____

Do you have a history of eye or vision problems (glasses, contact or eye diseases)? _____

Do you hear clicking or other sounds, when you move your eyes? Yes No

HEARING

Do you have any problems with your hearing? Yes No
If yes, is one ear better or worse then the other? Right Left Same

Does your hearing fluctuate? Yes No

Have you ever had ear surgery? Yes No
If yes, explain: _____

Do you have ear pain? Right Left Both None

Do you have drainage from your ears other than wax? Right Left Both None

Do you have fullness or plugged sensation in your ears? Right Left Both None

Do you have ringing or roaring in your ears? Right Left Both None
Is the ringing? Constant Periodic Like a heartbeat

Do loud noises seem to effect symptoms? Yes No

MEDICAL HISTORY

What type of testing have you had for your dizziness? _____

Please list any other health problems not mentioned. _____

Please list any prior surgeries. _____

Please list all current medications. _____

Have you taken any medications for your dizziness? Yes No
If yes, what type and was it helpful? _____

Is there anything that you would like to add that was not asked on this questionnaire?

