THE EAR INSTITUTE OF TEXAS P.A.

Dizziness Questionnaire

The patient history and a description of the symptoms are extremely important in making a correct diagnosis. Please answer yes or no, circle the appropriate answer, or fill in the appropriate blanks for EACH QUESTION.

1. Describe your dizziness symptoms.
   - Yes No a) Spinning vertigo
   - Yes No b) Lightheadedness/wooziness
   - Yes No c) Imbalance/trouble walking/trouble standing
   - Yes No d) Veering or falling: ____ To the right ____ To the left ____ Forward ____ Backward
   - Yes No e) Delayed focusing of visual fields
   - Yes No f) Visual blurring during head motion
   - Yes No g) Blacking out (If yes, do you lose consciousness? ____ Yes ____ No)

2. When was your first dizzy episode? (date) __________________________

3. When did the most recent dizziness episode begin? (Date) __________________________

4. Is the dizziness constant or recurrent? ____ Constant ____ Recurrent ____ Constant when walking

5. How long do the episodes last? __________________________

6. How often do the episodes occur? __________________________

7. Rate the severity of the dizziness. (10 is the MOST severe) _______________

8. Is the dizziness: (Circle) Improving Getting worse The same

**Modifying Factors**

9. ____ Yes ____ No Is the dizziness triggered by rapid movements of the head or body? (If yes, circle those that apply)
   - All rapid head movements
   - Lying down
   - Looking up
   - Rising or bending over
   - Getting out of bed
   - Turning head to the right
   - Turning head to the left
   - Rolling right in bed
   - Rolling left in bed

10. Do any of the following trigger the dizziness? (If yes, circle those that apply)
    - Caffeine
    - Salt
    - Other dietary items
    - Stress/fatigue
    - Emotional change
    - Allergies
    - Other __________________________

11. What, if anything, makes your dizziness better? (list) __________________________

12. ____ Yes ____ No Have you experienced motion sickness?

13. ____ Yes ____ No Do you have problems walking in the dark?

14. ____ Yes ____ No Do you require assistance when walking? Sometimes/Always (Circle those that apply) Companion Cane Walker

15. ____ Yes ____ No Did you suffer a cold, flu, or other infectious symptoms at the time your dizziness began?

16. ____ Yes ____ No Have you suffered: (Circle those that apply) Head trauma Concussion Stroke TIA (mini-stroke)

**Associated Signs and Symptoms**

17. ____ Yes ____ No Do you experience increased ear ringing with your dizzy spells? ……
    - Which ear? □ Right □ Left

18. ____ Yes ____ No Do you suffer increased hearing loss with your dizzy spells? ………
    - Which ear? □ Right □ Left

19. ____ Yes ____ No Do you suffer increased pressure in your ears with your dizzy spells? …
    - Which ear? □ Right □ Left

20. ____ Yes ____ No Do you experience nausea or vomiting with the dizzy spells? (Circle) Nausea Vomiting

21. ____ Yes ____ No Have you experienced falls?

22. ____ Yes ____ No Do you suffer from recurrent headaches or pressure in the head? Location: __________________________

23. ____ Yes ____ No Do the headaches occur at the same time and the dizziness?

24. Are your headaches associated with any of the following symptoms? (Please circle all that apply)
    - Throbbing head pain
    - Moderate or severe head pain
    - Visual spots/ Squiggly lines
    - Sensitivity to bright lights
    - Sensitivity to loud noises
    - Nausea
    - Vomiting

25. ____ Yes ____ No Have you seen any other doctors for evaluation of this problem? (Provide name) __________________________

26. ____ Yes ____ No Have you been diagnosed with a specific ear or balance problem? __________________________

27. ____ Yes ____ No Have you had other tests completed? (If yes, circle all those that apply.)
    - Hearing Test
    - Vestibular/Balance testing
    - MRI scan of the brain
    - CT scan of the brain
    - Carotid ultrasound
    - Heart Testing

Name (print): __________________________ Signature: __________________________ Date: ______________