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)

Duration, Timing, Context and Severity

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? _____ (circle) … ***Seconds Minutes Hours Days***
6. How often do the episodes occur? _____ per (circle) … ***Day Week Month Year***
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 Bending over Rising 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 changes Allergies Automobile rides

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 each dizzy spell? …….. Which ear? □Right □Left
18. ___Yes ___No Do you suffer increased hearing loss with each dizzy spell? …… Which ear? □Right □Left
19. ___Yes ___No Do you suffer increased ear pressure in your ears with each dizzy spell? … 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 as 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: _____