ALBANY ENT & Allergy Services, PC

DIZZINESS QUESTIONNAIRE

Name: _____

Age: _____ Sex: _____ Date: _____

The following questions refer to your feeling of dizziness. Please answer them by circling "yes" or "no" and fill in all blanks.

Please describe the sensation you feel in your own words without using the word "dizzy."

_____

_____

Medicines

Please list all medicines you are currently taking (including pain medicines, nonprescription medicines, nerve pills, sleeping pills, and birth control).

_____

_____

_____

What **studies** have been done previously regarding your dizziness? i.e., hearing test, CT scan brain, MRI scan brain or balance testing (ENG)?

_____

_____

Do you ever have any of the following sensations	**Yes**	**No**
Spinning in circles?	□	□
Falling to one side?	□	□
World spinning around you?	□	□
The following questions refer to a typical dizzy spell:	**Yes**	**No**
Do the dizzy spells come in attacks?	□	□
How often?		
How long?		
Date of first spell?		
Are you free from dizziness between attacks?	□	□
Does your hearing change with an attack?	□	□
Are you dizzier in certain positions?	□	□
Which position?		
Are you nauseated during an attack?	□	□
Had a recent cold or flu preceding recent dizzy spells?	□	□
Fullness or pressure or ringing in your ears?	□	□
Recent onset of pain or discharge in your ear?	□	□
Trouble walking in the dark?	□	□
Are you better if you sit or lie perfectly still?	□	□

The following questions refer to other sensations you may have:	**Yes**	**No**
Do you black out or faint when you are dizzy?	□	□
Are you dizzy or unsteady constantly?	□	□
Any double or blurry vision?	□	□
Numbness in your face or extremities?	□	□
Weakness or clumsiness in arms, legs?	□	□
Slurred or difficult speech?	□	□
Difficulty swallowing?	□	□
Tingling around your mouth?	□	□
Spots before your eyes?	□	□
Jerking of arms and legs?	□	□
Head injury with loss of consciousness?	□	□
Confusion or memory loss?	□	□
The following questions refer to your hearing:	**Yes**	**No**
Difficulty hearing in one ear? L R	□	□
Ringing in one ear? L R	□	□
Fullness in one ear? L R	□	□
Changes in hearing when dizzy? If Yes, how:	□	□
Exposure to loud noise?	□	□
Previous ear infections?	□	□
Previous ear surgery?	□	□
What Kind? When?		
Family history of deafness?	□	□
Pain in ears? L R	□	□
Discharge from ears? L R	□	□
Hearing changing? L R	□	□
Better? L R	□	□
Worse? L R	□	□
The following questions refer to habits and lifestyle:	**Yes**	**No**
Is there added stress in your life recently?	□	□
Is your dizziness related to:		
Moments of stress?	□	□
Menstrual period?	□	□
Overwork or exertion?	□	□
Do you feel lightheaded or have a swimming sensation when you are dizzy?	□	□
Do you find yourself breathing faster or deeper when excited or dizzy?	□	□
Did you recently change eyeglasses?	□	□
Do you drink coffee? If Yes, How much per day?	□	□
Do you drink tea? If Yes, How much per day?	□	□
Do you drink alcohol? If Yes, How much per day?	□	□
Do you smoke?	□	□
What? How much per day?	□	□

Miscellaneous:	**Yes**	**No**
Are you allergic to any medicines?	□	□
What?		
Are you allergic to anything?	□	□
What?		
Have you ever had weakness or faintness a few hours after eating?	□	□
Are you dizzy mainly when you sit or stand up quickly?	□	□

I have reviewed the above information with the patient.

_____ Date:_____