

Delray Office Plaza
6110 W Atlantic Ave
Suite A
Delray Beach, FL 33484

Tel: 561-638-6530
Fax: 561-638-6531



"For All Your Hearing Health Care Needs"

Anasca Professional Building
7593 Boynton Beach Blvd
Suite 100
Boynton Beach, FL 33437

Tel: 561-736-6002
Fax: 561-736-8878

Patient Name: _____

Date: _____

DIZZINESS QUESTIONNAIRE

Please answer all of the following questions by checking the appropriate responses or by filling in relevant blanks.

CHARACTERIZE YOUR DIZZINESS

- | | | |
|--|------------------------------|-----------------------------|
| 1. Lightheadedness, fainting, giddiness. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Unsteadiness. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. I or my surroundings seem to be moving. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. I am able to go on with my usual activities while dizzy. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. I am able to go on with only some of my usual activities while dizzy. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. I am completely incapacitated and must go to bed while dizzy. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

ONSET AND COURSE

7. Date of first dizziness _____
- | | | |
|--|--|----------------------------------|
| 8. My dizziness is constant. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. My dizziness comes in attacks. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| a. If in attacks, how often? | <input type="checkbox"/> Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Weekly | <input type="checkbox"/> Monthly |
| b. How long do they last? | <input type="checkbox"/> Seconds <input type="checkbox"/> Minutes <input type="checkbox"/> Hours | <input type="checkbox"/> Days |
| 10. My dizziness comes on suddenly. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. My dizziness comes on gradually. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. I am completely free of dizziness between attacks. | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 13. I can tell when an attack is about to start. Describe how: | _____ | |

ASSOCIATED SYMPTOMS

- | | | |
|--|--|------------------------------------|
| 14. Nausea or vomiting? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. Sweating? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 16. Deafness or difficulty hearing? | <input type="checkbox"/> Right ear <input type="checkbox"/> Left ear | <input type="checkbox"/> Both ears |
| 17. Any noises (buzzing or ringing in the ears)? | <input type="checkbox"/> Right ear <input type="checkbox"/> Left ear | <input type="checkbox"/> Both ears |
| 18. Any change in this noise with dizziness? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 19. Fullness or pain in ears? | <input type="checkbox"/> Right ear <input type="checkbox"/> Left ear | <input type="checkbox"/> Both ears |
| 20. Drainage from ears? | <input type="checkbox"/> Right ear <input type="checkbox"/> Left ear | <input type="checkbox"/> Both ears |
| 21. Tendency to fall? | <input type="checkbox"/> Right <input type="checkbox"/> Left | <input type="checkbox"/> Either |
| 22. Tendency to veer when walking? | <input type="checkbox"/> Right <input type="checkbox"/> Left | <input type="checkbox"/> Either |

23. Headache or pressure in head? During After None
Where? _____
24. Weakness or clumsiness in arms or legs? Yes No
25. Difficulty with speech or swallowing? Yes No
26. Blackouts? Loss of consciousness? Confusion? Loss of memory?
27. Rapid heartbeat/palpitations? Double Vision? Blurred Vision? Blindness?
28. Shortness of breath during the attack? Yes No
29. Numbness or tingling of face, fingers or toes? Yes No
30. Pain or stiffness of the neck? Yes No

EXACERBATING AND REMITTING FACTORS

31. Does turning your head bring on or make your dizziness worse? Yes No
Which direction? _____
32. Does lying down or sitting up bring on your dizziness? Yes No
33. Does standing up bring on your dizziness? Yes No
34. Do you find it especially difficult to walk in the dark? Yes No
35. Is there any relationship between your dizziness and tension or anxiety in your life? Yes No
If yes, Explain _____
36. Do you know of anything that will precipitate an attack? Yes No
What? _____
37. Is there anything that will stop or make your dizziness better? Yes No
What? _____

PRESENT/PAST MEDICAL HISTORY

38. Have you ever had a concussion, skull fracture or been knocked unconscious? Yes No
39. Have you ever had a whiplash or do you have a neck disease? Yes No
40. Do you have an eye disorder or wear glasses? Yes No
41. Have you ever had ear infections or other ear disease? Yes No
42. Had you been taking prescription or nonprescription medications regularly before your dizziness started? Yes No
If yes, list them _____
43. Do you have allergies? To what? _____
44. Have you in the past or do you currently smoke? Yes No
Packs per day _____ How many years? _____
45. Have you been in the past or are you now a heavy drinker? Yes No
46. Have you in the past or do you now have:
 Diabetes High Blood Pressure Migraines Seizures Cancer Stroke Heart Attack
47. Do you know of any possible cause of your dizziness? Yes No
What? _____
48. Has another doctor performed tests to evaluate your dizziness? Yes No
Dr. _____ Phone (____) _____ Date _____
49. Do you wear an intracardiac catheter or pacemaker with exposed leads? Yes No