The Barranco Clinic

Name_____ **Date**_____

Dizziness Questionnaire

I. When you are "dizzy" do you experience any of the following sensations? Please read the entire list first. Then put an "X" in either the first box for YES or the second box for NO to describe your feelings most accurately.

YES	NO		
____	____	1.	Lightheadedness.
____	____	2.	Swimming sensation in the head.
____	____	3.	Blacking out.
____	____	4.	Loss of consciousness.
____	____	5.	Tendency to fall: To the right? To the left? Forward? Backward?
____	____	6.	Objects spinning or turning around you.
____	____	7.	Sensation that you are turning or spinning inside, with outside objects remaining stationary.
____	____	8.	Loss of balance when walking: Veering to the right? Veering to the left?
____	____	9.	Headache.
____	____	10.	Nausea or vomiting.
____	____	11.	Pressure in the head.

II. Please check box for either YES or NO and fill in the blank spaces.

YES	NO		
____	____	1.	My dizziness is constant? in attacks?
		2.	When did dizziness first occur? _____
		3.	If in attacks: How often? _____ How long do they last? _____ Do you have any warning that the attack is about to start?
____	____	4.	Are you completely free of dizziness between attacks?
____	____	5.	Does dizziness occur only in certain positions?
____	____	6.	Do you have trouble walking in the dark?
____	____	7.	When you are dizzy, must you support yourself when standing?
____	____	8.	Do you know of any possible cause of your dizziness? What? _____
		9.	Do you know of anything that will:
____	____		Stop your dizziness or make it better?
____	____		Make your dizziness worse?
____	____		Precipitate an attack?
____	____	10.	Were you exposed to any irritating fumes, paints, etc., at the onset of dizziness?
____	____	11.	Do you have any allergies?
____	____	12.	Did you ever injure your head?
____	____		Were you unconscious?
____	____	13.	Do you take any medications regularly? (i.e., tranquilizers, oral contraceptives, barbiturates, antibiotics). What? _____
____	____	14.	Do you use tobacco in any form? How much? _____
____	____	15.	Do you use alcohol?
____	____	16.	Have you ever had ear surgery?

Type & Date: _____

_____

III. Do you have any of the following symptoms? Put an "X" in either the first box for YES or the second box for NO and circle ear involved.

YES	NO		
_____	_____	1.	Difficulty in hearing? Both ears Right Left
			When did this start? _____
_____	_____		Is it getting worse?
_____	_____	2.	Noise in your ears? Both ears Right Left
			Describe the noise _____
_____	_____		Does noise change with dizziness? If so, how? _____
_____	_____	3.	Fullness or stuffiness in your ears? Both ears Right Left
_____	_____		Does this change when you are dizzy?
_____	_____	4.	Pain in your ears? Both ears Right Left
_____	_____	5.	Discharge from your ears? Both ears Right Left

IV. Have you ever experienced any of the following symptoms? Put an "X" either in the first box for YES or the second box for NO and circle if Constant or in Episodes.

YES	NO				
_____	_____	1.	Double vision.	Constant	Episodes
_____	_____	2.	Numbness of face or extremities.	Constant	Episodes
_____	_____	3.	Blurred vision or blindness.	Constant	Episodes
_____	_____	4.	Weakness in arms or legs.	Constant	Episodes
_____	_____	5.	Clumsiness in arms or legs.	Constant	Episodes
_____	_____	6.	Confusion or loss of consciousness.	Constant	Episodes
_____	_____	7.	Difficulty with speech.	Constant	Episodes
_____	_____	8.	Difficulty with swallowing.	Constant	Episodes
_____	_____	9.	Tingling around the mouth.	Constant	Episodes
_____	_____	10.	Spots before the eyes.	Constant	Episodes

V. Please check box for either YES or NO.

YES	NO		
_____	_____	1.	Do you get dizzy after exertion or overwork?
_____	_____	2.	Did you get new glasses recently?
_____	_____	3.	Do you tend to get upset easily?
_____	_____	4.	Do you get dizzy when you have not eaten for a long time?
_____	_____	5.	Is your dizziness connected with your menstral period?
_____	_____	6.	Have you ever had a neck injury?

END OF QUESTIONNAIRE

MEDICATION IN PAST 48 HOURS

Sleeping pills	Alcohol
Tranquilizers	Anti-vertiginous
Antihistamines	Other

PAST MEDICAL HISTORY

Medical Illnesses _____
Diabetes
High Blood Pressure
Other _____
Surgery _____
_____

EXAMINATION

Blood Pressure: Right: Sit Left: Sit
Stand Stand

Head:
Eyes: Pupils
EOM's
Corneal Reflex
Nystagmus: Spontaneous Positional
Ears: Pinna
External Auditory Canals
Tympanic Membranes Right Left
Nose: Septum
Turbinates
Mouth: Hypopharynx
Larynx
Neck: Bruit:
Cranial Nerves:
III, IV, VI
VI
VII
VIII
IX Weber Rinne: Right Left
XI
XII
DTR's

CEREBELLAR TESTS

Romberg:
Tandem Romberg:
Finger to Nose:
Knee-Heel
Walking with Eyes Closed
Diadochokinesis

Calorics: Left
30° Right

CONCLUSION:

ADDITIONAL TESTS:

Rx: