

Coastal Ear, Nose & Throat

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

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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, barbitu-
rates, 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

<u> </u>	<u> </u>	1. Difficulty in hearing?	Both ears	Right	Left
<u> </u>	<u> </u>	When did this start? _____			
<u> </u>	<u> </u>	Is it getting worse? _____			
<u> </u>	<u> </u>	2. Noise in your ears?	Both ears	Right	Left
<u> </u>	<u> </u>	Describe the noise _____			
<u> </u>	<u> </u>	Does noise change with dizziness? If so, how? _____			
<u> </u>	<u> </u>	3. Fullness or stuffiness in your ears?	Both ears	Right	Left
<u> </u>	<u> </u>	Does this change when you are dizzy? _____			
<u> </u>	<u> </u>	4. Pain in your ears?	Both ears	Right	Left
<u> </u>	<u> </u>	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

<u> </u>	<u> </u>	1. Double vision.	Constant	Episodes
<u> </u>	<u> </u>	2. Numbness of face or extremities.	Constant	Episodes
<u> </u>	<u> </u>	3. Blurred vision or blindness.	Constant	Episodes
<u> </u>	<u> </u>	4. Weakness in arms or legs.	Constant	Episodes
<u> </u>	<u> </u>	5. Clumsiness in arms or legs.	Constant	Episodes
<u> </u>	<u> </u>	6. Confusion or loss of consciousness.	Constant	Episodes
<u> </u>	<u> </u>	7. Difficulty with speech.	Constant	Episodes
<u> </u>	<u> </u>	8. Difficulty with swallowing.	Constant	Episodes
<u> </u>	<u> </u>	9. Tingling around the mouth.	Constant	Episodes
<u> </u>	<u> </u>	10. Spots before the eyes.	Constant	Episodes

V. Please check box for either YES or NO.

YES NO

<u> </u>	<u> </u>	1. Do you get dizzy after exertion or overwork?
<u> </u>	<u> </u>	2. Did you get new glasses recently?
<u> </u>	<u> </u>	3. Do you tend to get upset easily?
<u> </u>	<u> </u>	4. Do you get dizzy when you have not eaten for a long time?
<u> </u>	<u> </u>	5. Is your dizziness connected with your menstrual period?
<u> </u>	<u> </u>	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 Stand	Left:	Sit 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: