DIZZINESS QUESTIONNAIRE

Please complete this form in its entirety as it is extremely important in making a correct diagnosis.

Dizziness symptoms:

Spinning vertigo? **YES NO**
Lightheadedness/wooziness? **YES NO**
Imbalance/ trouble walking/ trouble standing? **YES NO**
Veering or falling? **YES NO**
If yes, to the: **Right Left Forward Backward**
Delayed focusing of visual fields? **YES NO**
Visual blurring during head motion? **YES NO**
Blacking out? **YES NO**
If yes, do you lose consciousness? **YES NO**

Modifying Factors:

Is the dizziness triggered by rapid movements?
YES NO

If yes, <u>circle</u> those that apply:

All rapid head movements
Turning head to the right
Turning head to the left
Rising or bending over
Getting out of bed
Lying down
Looking Up
Rolling right in bed
Rolling left in bed

Do any of the following trigger the dizziness? **YES NO**
If yes, <u>circle</u> those that apply:

Caffeine Salt Fatigue

Stress Emotional Change Allergies

Other Dietary Items: ______________________________

Other: ______________________________

What makes your dizziness better? ____________________
Have you experienced motion sickness? **YES NO**
Do you have problems walking in the dark? **YES NO**
Do you require assistance when walking? **YES NO**
If so, sometimes or always? **Sometimes/ Always**
Do you use assistance? **YES NO**
If so, what do you use? **Companion/ Cane/ Walker**
Do you suffer a cold, flu, or other infectious symptoms at the time your dizziness begins? **YES NO**
Have you suffered any brain related events? **YES NO**
If yes, <u>circle</u> those that apply:
Head Trauma Concussion Stroke TIA (mini-stroke)

Patient Information

Patient Name: ______________________________

DOB: ________________

Today's Date: ________________

Duration, Timing, Context, and Severity:

Date of 1st dizzy episode? __________________________

When did most recent episode begin? __________________

Is it constant or recurrent? **Constant Recurring**
Constant when walking? **YES NO**
Length of episodes: **Seconds/ Minutes/ Hours/ Days**
Frequency of episodes: **Days/ Weeks/ Months/ Years**
Severity (10 is MOST severe)? ____________
Is the dizziness…
Improving Worsening Staying the Same

Associated Signs and Symptoms:

Do you experience increased ear ringing with your dizzy spells? **YES NO**
If yes, which ear? **LEFT RIGHT**
Do you suffer increased hearing loss with your dizzy spells?
YES NO If yes, which ear? **LEFT RIGHT**
Do you suffer increased pressure in your ears with your dizzy spells? **YES NO**
If yes, which ear? **LEFT RIGHT**
Do you experience nausea or vomiting with the dizzy spells?
NO YES NAUSEA VOMITTING
Have you ever experienced falls? **YES NO**
Do you suffer from recurrent headaches or pressure in the head? **YES NO**
If yes, where? ______________________________
Do the headaches occur at the same time as the dizziness?
YES NO

Are your headaches associated with any of the following symptoms: **(<u>Circle</u> all that apply)**
Throbbing head pain Moderate of severe head pain
Visual spots/squiggly lines Sensitivity to loud noises
Sensitivity to bright lights Nausea Vomiting

Previous History:

Have you seen any other providers for evaluation of this problem? If yes, who/where? ____________________
Have you been diagnosed with a specific ear or balance problem? If so, what? ______________________
Have you had any other test(s) completed? **YES NO**
(<u>Circle</u> all that apply)

Hearing test Vestibular/ Balance Testing
MRI of the brain CT of the brain
Carotid Ultrasound Heart Testing

Anne Arundel ENT & Facial Plastic Surgery