Blue Ridge Hearing and Balance Clinic
Dizziness History Questionnaire

Name:_____ **Age:**_____ **Date**:_____

WHEN was the first time ever in your life you had dizziness? _____

WHAT were the circumstances? _____
_____

WHEN was the last time you experienced dizziness? _____

WHAT were the circumstances? _____
_____

Currently, my dizziness…
__ is constant.
__ is always there, but changes in intensity.
__ comes and goes.

If comes and goes:
How long does it typically last? ___ seconds / minutes / hours (Circle ONE)
How often does it typically occur? ___ times per: hour / day / week / month / year

My dizziness mostly consists of…(Check ALL that apply)
__ spells of spinning with nausea.
__ off-balance sensation without dizziness.
__ a light-headed or near faint sensation.
__ other. Please explain _____

Between episodes I feel…(Check ONE)
__ dizzy or off balance all the time.
__ normal.
__ other. Please explain _____

My episodes occur…(Check ALL that apply)
__ spontaneously. Nothing I do seems to bring them on or turn them off.
__ only when standing or walking.
__ in relation to any head motion.
__ in relation to only certain head positions. Please describe _____

When I roll over in bed…(Check ONE)
__ nothing unusual happens.
__ the room seems to spin sometimes.
__ the room spins every time.

Is there anything that you can do to make you dizziness go away? (sit, lay down, close eyes…)
Please explain: _____
_____

Circle all that apply:

I have hearing difficulty …….Right …..Left…..Both
I have ringing or other sounds ……Right …..Left.….Both
I have fullness ……..…..Right ..…Left…..Both
I have had ear surgery …….Right ..…Left…..Both

Circle YES or NO

Did you have cold, flu or virus type symptoms shortly before the onset of your dizziness? YES / NO
Did you cough, lift, sneeze, fly in a plane, swim under water or have a head trauma shortly before the onset of your dizziness? YES / NO
If you had head trauma prior to your dizziness, did you lose consciousness completely? YES / NO
Were you exposed to any irritating fumes, paints, etc. at the onset of your dizziness? YES / NO
Do you get dizzy when you have not eaten for a long time? YES / NO
I your dizziness connected with your menstrual period? YES / NO
Did you get new glasses recently? YES / NO
I consider myself to be an anxious or tense type of person… YES / NO
I am under a great deal of stress… YES / NO

In the past year I have had…(Check ALL that apply)

__ loss of consciousness
__ seizures or convulsions
__ slurring of speech
__ difficulty swallowing
__ weakness in one hand, arm or leg
__ double vision
__ spots before the eyes
__ occasional loss of vision
__ severe pounding headache or migraine
__ palpitations of the heartbeat
__ tingling around mouth
__ tendency to fall
__ loss of balance when walking

I have or have had…(Check ALL that apply)

__ Diabetes
__ High blood pressure
__ Arthritis
__ Irregular heartbeat
__ Stroke
__ Migraine headaches
__ A neck and/or back injury
__ Allergies

Please check below for any MEDICATIONS you have tried FOR DIZZINESS or are currently taking:

	Taken in past	Taking now	Helps
Antivert (Meclizine)	___	___	___
Valium (Diazepam)	___	___	___
Dyazide "water pills"	___	___	___

Have you ever been previously evaluated for dizziness? _____

_____