

Professional Hearing Services

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The Dizziness Questionnaire

Name: _____ Date of exam: _____
DOB: _____ Age: _____ Referring Doctor: _____
Height: _____

Please answer these questions to the best of your ability.

Which of the following best describes your dizziness? Check only one.

- The sensation of movement the room or yourself: spinning, tilting, or wave-like motion
- Lightheadedness/the sensation of fainting
- Disorientation of the world
- Loss of balance

When did the dizziness first occur? _____

Is the dizziness constant or does it come in episodes? _____

If the dizziness occurs in episodes, how often do they occur? _____ times per day / week / month / year

How long do the episodes last? Seconds Minutes Hours Days

Since the first episode, are they becoming: more frequent less frequent the same

Are you having any symptoms now? _____

Does anything make your dizziness better? _____

Please check the following that increases/ provokes your dizziness:

- | | | |
|---|--|--|
| <input type="checkbox"/> Changes in weather | <input type="checkbox"/> Changes in body positions | <input type="checkbox"/> Looking up/down |
| <input type="checkbox"/> Walking in the dark | <input type="checkbox"/> Walking up/down stairs | <input type="checkbox"/> Riding in elevators |
| <input type="checkbox"/> Walking around corners | <input type="checkbox"/> Walking in shopping malls | <input type="checkbox"/> Head movements |
| <input type="checkbox"/> Loud noises | <input type="checkbox"/> Stress | <input type="checkbox"/> Other: _____ |

Please check the following that bother you when dizzy:

- | | | |
|---|---|--|
| <input type="checkbox"/> Riding through tunnels | <input type="checkbox"/> Ladders/heights | <input type="checkbox"/> Driving/riding in a car |
| <input type="checkbox"/> Riding in an airplane | <input type="checkbox"/> Riding in a boat | <input type="checkbox"/> Reading in a car |

If you have an earache, are you also dizzy at that time? Yes No

Do you think your dizziness is related to menstrual periods/menopause? Yes No N/A

Is your dizziness worse when you are tired? Yes No

Have you experienced sudden falls while standing/walking? Yes No

Would you describe your gait as steady? Yes No

When you are dizzy do you experience any of the following? Check as many as needed.

- | | |
|--|---|
| <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Migraine/headache |
| <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Tendency to fall (right or left) |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Lightheadedness |
| <input type="checkbox"/> Other, Please specify _____ | |

- Do you think you have hearing loss? Yes No
 If yes, which ear(s)? _____
 Was the loss sudden or gradual? _____
- Do you feel your hearing fluctuates with dizziness? Yes No
 Have you experienced loud noise exposure? Yes No
 Do you experience tinnitus? Yes No
 If yes, please describe (buzzing, hissing, etc) _____
- Do you have pressure/fullness in your ears? Yes No
 If yes, which ear(s)? _____
- Do you have numbness/tingling around your ear(s)? Yes No
 If yes, which ear(s)? _____
- Do you experience chronic ear infections? Yes No
 If yes, when was the last one? _____
- Are you aware of a perforated ear drum? Yes No
 If yes, which ear(s)? _____
- Have you had any ear surgeries? Yes No
 If yes, please describe: _____
- Do you drink alcohol? Yes No
 If yes, how many drinks per day? _____
- Do you smoke? Yes No
 If yes, how many cigarettes per day? _____
- Have you smoked in the past? Yes No
 When did you quit? _____
- Do you consume caffeinated beverages? Yes No
 If yes, how many of the following?
 Cups of coffee ____ Cups of cocoa ____
 Cups of tea ____ Cola drinks ____
- Do you consume a lot of sugar? Yes No
 Do you consume excessive salt? Yes No
 Do you feel you have insomnia? Yes No
 How many hours of sleep do you get per night? _____
- Do you exercise? Yes No
 If yes, how often per week? _____
 What type of exercise? _____

Please list all your current medications, including hormones, birth controls, vitamins, etc...

Name	Dosage	Amount per day

What medications have been taken for *dizziness*?

	Did it help? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Did it help? <input type="checkbox"/> Yes <input type="checkbox"/> No

Please list any allergies to medications:

Please check those items you have experienced and dates:

- | | | |
|--|---|---|
| <input type="checkbox"/> Low back pain _____ | <input type="checkbox"/> Neck pain _____ | <input type="checkbox"/> Foot problems _____ |
| <input type="checkbox"/> Loss of feeling in feet/ legs _____ | <input type="checkbox"/> Neck injury _____ | <input type="checkbox"/> Whiplash _____ |
| <input type="checkbox"/> Ankle sprain / fracture _____ | <input type="checkbox"/> Knee Injury _____ | <input type="checkbox"/> Hip Injury _____ |
| <input type="checkbox"/> Loss of consciousness _____ | <input type="checkbox"/> Head injury _____ | <input type="checkbox"/> Concussion _____ |
| <input type="checkbox"/> Irregular heart beat _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Eye problem _____ |
| <input type="checkbox"/> Headaches/migraines _____ | <input type="checkbox"/> Cataracts _____ | <input type="checkbox"/> Loss of vision _____ |
| <input type="checkbox"/> Low blood sugar _____ | <input type="checkbox"/> High cholesterol _____ | <input type="checkbox"/> Heart attack _____ |
| <input type="checkbox"/> Cardiac surgery _____ | <input type="checkbox"/> TMJ _____ | <input type="checkbox"/> Jaw pain _____ |
| <input type="checkbox"/> Recent dental work _____ | <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> Treatment by a psychiatrist _____ | <input type="checkbox"/> Convulsion _____ | <input type="checkbox"/> Depression _____ |
| <input type="checkbox"/> Unusual stress _____ | <input type="checkbox"/> Panic attacks _____ | <input type="checkbox"/> Seizure _____ |
| <input type="checkbox"/> Treatment by a psychologist _____ | <input type="checkbox"/> Chemotherapy _____ | <input type="checkbox"/> Other _____ |

Have you had any of the following? Check all that apply:

- | | | | |
|--|---|---------------------------------------|-----------------------------------|
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Insect bites | <input type="checkbox"/> Tick bites | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Exposure to HIV | <input type="checkbox"/> Measles | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Venereal diseases | <input type="checkbox"/> Exposure to AIDS | <input type="checkbox"/> Epstein Barr | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Blood transfusion in the last 5 years | | | |

Check all that apply. Please include the date of test, where the test was performed and the results of the testing

- | | | |
|---|--|---|
| <input type="checkbox"/> Hearing test _____ | <input type="checkbox"/> ENG (Electronystagmography) _____ | |
| <input type="checkbox"/> EEG _____ | <input type="checkbox"/> CT Scan of brain _____ | |
| <input type="checkbox"/> EKG _____ | <input type="checkbox"/> CT Scan of ears _____ | |
| <input type="checkbox"/> Rotary Chair Test _____ | <input type="checkbox"/> OAE (Otoacoustic Emissions) _____ | |
| <input type="checkbox"/> Neck X-rays _____ | <input type="checkbox"/> V.A.T. (Vestibular Autorotation Test) _____ | |
| <input type="checkbox"/> ECOG (Electrocochleography) _____ | <input type="checkbox"/> Balance Platform Test (Posturography) _____ | |
| <input type="checkbox"/> Complete Physical _____ | <input type="checkbox"/> Neurology Evaluation _____ | |
| <input type="checkbox"/> Holter monitor testing _____ | <input type="checkbox"/> Lumbar Puncture (Spinal Fluid Study) _____ | |
| <input type="checkbox"/> MRA _____ | <input type="checkbox"/> Carotid artery doppler flow study _____ | |
| <input type="checkbox"/> BAER / ABR (brainstem auditory evoked response /auditory brainstem response) _____ | | |
| <input type="checkbox"/> MRI of brain _____ | <input type="checkbox"/> with contrast | <input type="checkbox"/> without contrast |
| <input type="checkbox"/> MRI of ears _____ | <input type="checkbox"/> with contrast | <input type="checkbox"/> without contrast |