Dizziness History Questionnaire

This form is to be completed along with the Adult Hearing Health History.
Please bring both to your appointment.

Name: _____ Date of Birth: _____

When did your dizziness/imbalance start? _____ Was onset gradual or sudden? □ Gradual □ Sudden

Describe in your own words *how your symptoms started* and *how it feels*: _____

_____

_____

_____

Do you feel dizzy/off-balance now? □ YES □ NO

Do you feel dizzy/off-balance all the time? □ YES □ NO If NO, how often? _____

Is it constant or it comes and goes? □ Constant □ Comes and goes and lasts: _____

If it comes and goes, do you have any warning it will occur? □ YES □ NO

If YES, describe: _____

If YES, are you free of symptoms between attacks? □ YES □ NO

Is your dizziness/imbalance accompanied by: □ nausea □ ringing or noises in your ear(s) □ hearing loss
□ visual disturbances □ Other: _____

Do you have any neck or back problems/pain/surgeries? □ YES □ NO

Does your dizziness/imbalance occur with position changes? □ YES □ NO If YES, check all that apply:

□ Rolling your body right or left □ Turning your head left or right

□ Looking up, or head back position □ Bending over, or head down position

□ Going from lying to sitting position □ Other: _____

Do you know of anything that makes your dizziness/imbalance **better**? □ YES □ NO If YES, check all that apply:

□ Not moving your head □ Rest □ Medication: _____ □ Other: _____

Do your symptoms limit your daily activities? □ YES □ NO If YES, describe: _____

Do you have trouble walking in the dark or at dusk? □ YES □ NO

Do you have trouble walking on uneven surfaces (eg. lawn)? □ YES □ NO

Do you have migraine headaches? □ YES □ NO If YES, most recent: _____

Have you ever had IV antibiotics or chemotherapy? □ YES □ NO If YES, what, why, and when: _____

Have you ever suffered a concussion (head injury)? □ YES □ NO If YES, when: _____

Do you have pain, fullness, or pressure in your ears? □ YES □ NO If YES, which ear(s): □ Right □ Left □ Both

If YES, does it coincide with your dizziness/unsteadiness? □ YES □ NO

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Have you fallen in the last 12 months due to your dizziness/unsteadiness? □ YES □ NO

If YES, how many times in the last 12 months? _____ Were you injured at all? □ YES □ NO

If YES, please describe your injury: _____

If YES, do you tend to fall to the: □ Right □ Left □ Backwards □ Front □ No pattern

Do you currently take a Vitamin D supplement? □ YES □ NO

Have you taken any pain, sleep, anti-dizzy, anti-depressant, anti-anxiety, anti-epileptic medications in the past 24 hours? □ YES □ NO

If YES, what medication and why? _____

Have you consumed alcohol in the last 24-hours? □ YES □ NO

Do you experience any of the following *since your problem started*? (Indicate if constant or episodic):

Yes	No				Comments
□	□	1. Double/blurred vision or blindness	□ Constant	□ Episodic	
□	□	2. Numbness of face or extremities	□ Constant	□ Episodic	
□	□	3. Weakness in arms or legs	□ Constant	□ Episodic	
□	□	4. Clumsiness in arms or legs	□ Constant	□ Episodic	
□	□	5. Confusion or loss of consciousness	□ Constant	□ Episodic	
□	□	6. Difficulty with speech or swallowing	□ Constant	□ Episodic	

Have you seen other healthcare providers for your dizziness/imbalance? □ YES □ NO

If YES, who: □ Primary MD □ Ear, Nose, Throat MD (ENT) □ Neurologist
□ Audiologist □ Cardiologist □ Emergency Room MD □ Physical Therapist

Have you had tests done for your dizziness elsewhere? □ YES □ NO

ENG/VNG Where: _____ When: _____ Results: _____

MRI/CT Where: _____ When: _____ Results: _____

Hearing tests Where: _____ When: _____ Results: _____

Other: _____

Signature: _____ **Date:** _____

Clinician Notes:

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