COCHISE EAR, NOSE AND THROAT ASSOCIATES, PLLC

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DIZZINESS QUESTIONAIRE

Name_____ Date_____

I. When you are "dizzy" do you experience any of the following sensations? Please read the entire list first.

Then check **Yes** or **NO** to describe your feelings most accurately.

Yes □ No □ 1. Lightheadedness or swimming sensation in the head.

Yes □ No □ 2. Blacking out or loss of consciousness.

Yes □ No □ 3. Tendency to fall: To the right?

Yes □ No □ To the left?

Yes □ No □ Forward?

Yes □ No □ Backward?

Yes □ No □ 4. Objects spinning or turning around you.

Yes □ No □ 5. Sensation that you are turning or spinning inside, with outside objects Remaining stationary.

Yes □ No □ 6. Sensation of the environment moving up and down while you walk.

Yes □ No □ 7. Loss of balance when walking: Veering to the right?

Yes □ No □ Veering to the left?

Yes □ No □ 8. Headache.

Yes □ No □ 9. Nausea or vomiting.

Yes □ No □ 10. Pressure in the head.

Yes □ No □ 11. Palpitations, perspiration, shortness of breath, or a feeling of panic.

Patient Name:_____ **Date Of Birth:**_____

II. Please check **YES** or **NO** and fill in the blank spaces: Answer all questions.

1. My dizziness is:

Yes □ No □ Constant?

Yes □ No □ In attacks?

2. When did dizziness first occur?_____
3. If in attacks: How often?_____
   How long do they last?_____
   When was the last attack?_____

Yes □ No □ Do you have any warning that the attack is about to start?

Yes □ No □ Do they occur at any particular time of day or night?

Yes □ No □ Are you completely free of dizziness between attacks?

Yes □ No □ 4. Does change of position make you dizzy?

Yes □ No □ 5. Do you have trouble walking in the dark?

Yes □ No □ 6. When you are dizzy, must you support yourself when standing?

Yes □ No □ 7. Do you know of any possible cause of your dizziness? What?____

8. Do you know of anything that will:

Yes □ No □ Stop your dizziness or make it better?_____

Yes □ No □ Make your dizziness worse?_____

Yes □ No □ Precipitate an attack?_____

(Fatigue? Exertion? Hunger? Menstrual Period? Stress? Emotional? Upset?)

Yes □ No □ 9. Where you exposed to any irritating fumes, paints, etc., at the onset of Dizziness?

Yes □ No □ 10. If you are allergic to any medications, please list:_____

Yes □ No □ 11. If you ever injured your head, were you unconscious?

Yes □ No □ 12. If you take any medications regularly, for any reason, please list:_____

Yes □ No □ 13. Do you use tobacco in any form?_____ How much?_____

Patient Name:_____ **Date Of Birth:**_____

III. Do you have any of the following symptoms? Please check **Yes** or **No** and check **Ear** involved.

Yes □ No □ 1. Difficult in hearing? Both ears □ Right □ Left □

Yes □ No □ 2. Noise in your ears? Both Ears □ Right □ Left □

2a. How loud is your tinnitus or head noise most of the time?

□ None	No head noise.
□Very Soft	Heard only in a quiet situation.
□ Moderate	Heard only in an ordinary situation.
□ Loud	Heard and noticed in all situations, even When concentrating on something else.

2b. Describe the noise_____

2c. Does noise change with dizziness? If so, how?_____

Yes □ No □ 3. Fullness of stuffiness in your ears? Both ears □ Right □ Left □

Yes □ No □ 4. Pain in your ears? Both ears□ Right □ Left □

Yes □ No □ 5. Discharge from your ears? Both ears □ Right □ Left □

IV. Have you ever experienced any of the following symptoms? Please check **Yes** or **No** and check **Constant** or in **Episodes.**

Yes □ No □ 1. Double vision, blurred vision or blindness. Constant□ In Episodes □

Yes □ No □ 2. Numbness of face. Constant □ In Episodes □

Yes □ No □ 3. Numbness of arms or legs. Constant □ In Episodes □

Yes □ No □ 4. Weakness in arms or legs. Constant □ In Episodes □

Yes □ No □ 5. Clumsiness of arms or legs. Constant □ In Episodes □

Yes □ No □ 6. Confusion of loss onconsciousness Constant □ In Episodes □

Yes □ No □ 7. Difficulty with speech. Constant □ In Episodes □

Yes □ No □ 8. Difficulty with swallowing. Constant □ In Episodes □

Yes □ No □ 9. Pain in the neck or shoulder. Constant □ In Episodes □

Yes □ No □ 10. Seasickness or car sickness Constant □ In Episodes