BURLINGTON EAR, NOSE & THROAT CLINIC, P.C.
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Name____________________________________ **Age**_____ **Sex**_____ **Date**____________________

The following questions refer to your feeling of dizziness. Please answer them as "yes" or "no" and fill in all the blanks.

1. Please describe, in your own words, the sensation you feel without using the word "dizzy."____

   ____

2. Do you ever have any of the following sensations:

   Yes Spinning in circles? No
   Yes Falling to one side? No
   Yes World spinning around you? No

3. The following refer to a typical dizzy spell:

   Yes Do the dizzy spells come in attacks? No

How often?______________________________________

How long?_______________________________________

   Date of first spell?__________________________________
   Yes Are you free from dizziness between attacks? No
   Yes Does you hearing change with an attack? No
   Yes Are you dizzy in certain positions? No
   Which position?___________________________________
   Yes Are you nauseated during an attack? No
   Yes Are you dizzy even when lying down? No
   Yes Had a recent cold or flu preceding recent dizzy spells? No
   Yes Fullness or pressure or ringing in your ears? No
   Yes Pain or discharge in your ear of recent onset? No
   Yes Trouble walking in the dark? No
   Yes Are you better if you sit or lie perfectly still? No

4. The following refer to other sensations you may have:

   Yes Do you black our or faint when you are dizzy? No
   Yes Are you dizzy or unsteady constantly? No
   Yes Do you have severe or recurrent headaches? No
   Yes Any double or blurry vision? No
   Yes Numbness in your face or extremities? No
   Yes Weakness or clumsiness in your arms, legs? No
   Yes Slurred or difficult speech? No
   Yes Difficulty swallowing? No
   Yes Tingling around your mouth? No
   Yes Spots before your eyes? No
   Yes Jerking of arms and legs? No
   Yes Head injury with loss of consciousness? No
   Yes Confusion or memory loss? No

5. The following refer to your hearing:

   Yes Difficulty hearing in one ear? Left____ Right____ No
   Yes Ringing in one ear? Left____ Right____ No

Yes	Fullness in one ear? Left____ Right____	No
Yes	Change in hearing when dizzy? How?____	No
Yes	Exposure to loud noises?	No
Yes	Previous ear infections?	No
Yes	Previous ear surgery? What?______________________________ When?_____________	No
Yes	Family history of deafness?	No
Yes	Pain in ears? Left____ Right____	No
Yes	Discharge from ears? Left_____ Right____	No
Yes	Hearing changing? Left____ Right_____	No
Yes	Better? Left____ Right____	No
Yes	Worse? Left____ Right____	No

6. The following refer to habits and lifestyle:

Yes	Is there added stress in your life recently?	No

7. Is your dizziness related to any of the following?

Yes	Moments of stress?	No
Yes	Menstrual period?	No
Yes	Overwork or exertion?	No
Yes	Do you feel lightheaded or have a swimming sensation when dizzy?	No
Yes	Do you find yourself breathing faster or deeper when excited or dizzy?	No
Yes	Did you recently change eyeglasses?	No
Yes	Do you drink coffee? How much?_______	No
Yes	Do you drink tea? How much?________	No
Yes	Do you drink soft drinks? How much?______	No
Yes	Do you drink alcohol? How much?______	No
Yes	Do you smoke? What?______ How much?______	No

8. What studies have been done previously (e.g., hearing, radiographs, head scans)?
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9. Do you have anything else to add about your particular problem that has not been addressed on this questionnaire?____
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