BURLINGTON EAR, NOSE & THROAT CLINIC, P.C.
DOUGLAS E. HENRICH, M.D. JENNIFER K. BERGE, M.D.

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.

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

_____

_____

Do you ever have any of the following sensations:

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

The following refers to a typical dizzy spell:

☐ Yes ☐ No Do the dizzy spells come in attacks?
How often? _____
How long? _____
Date of first spell? _____
☐ Yes ☐ No Are you free from dizziness between attacks?
☐ Yes ☐ No Does your hearing change with an attack?
☐ Yes ☐ No Are you dizzy in certain positions?
Which position? _____
☐ Yes ☐ No Are you nauseated during an attack?
☐ Yes ☐ No Are you dizzy even when lying down?
☐ Yes ☐ No Had a recent cold or flu preceding recent dizzy spells?
☐ Yes ☐ No Have fullness, pressure or ringing in your ears?
☐ Yes ☐ No Have a recent onset of pain or discharge in your ear?
☐ Yes ☐ No Have trouble walking in the dark?
☐ Yes ☐ No Are you better if you sit or lie perfectly still?

The following refers to other sensations you may have:

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

The following refers to your hearing:

☐ Yes ☐ No Difficulty hearing in one ear? Left _____ Right _____
☐ Yes ☐ No Ringing in one ear? Left _____ Right _____
☐ Yes ☐ No Fullness in one ear? Left _____ Right _____
☐ Yes ☐ No Change in hearing when dizzy? How? _____
☐ Yes ☐ No Exposure to loud noises?
☐ Yes ☐ No Previous ear infections?
☐ Yes ☐ No Previous ear surgery? What? _____ When? _____
☐ Yes ☐ No Family history of deafness?
☐ Yes ☐ No Pain in ears? Left _____ Right _____
☐ Yes ☐ No Discharge from ears? Left _____ Right _____
☐ Yes ☐ No Hearing changing? Left _____ Right _____
☐ Yes ☐ No Better? Left _____ Right _____
☐ Yes ☐ No Worse? Left _____ Right _____

The following refers to habits and lifestyle:

☐ Yes ☐ No Is there added stress in your life recently?

Is your dizziness related to any of the following?

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

What studies have been done previously (e.g., hearing, radiographs, head scans)? _____

_____

_____

Do you have anything else to add about your particular problem that has not been addressed on this questionnaire?

_____

_____

_____