ENT Assoc. of Charleston, Inc.

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DIZZINESS QUESTIONNAIRE

Name_____Date_____

1. When you are "DIZZY" do you experience any of the following sensations? Please read the entire list first. Then indicate any symptom that describes your feelings most accurately.

   ❑ lightheadedness
   ❑ blacking out
   ❑ loss of consciousness
   ❑ tendency to fall
   ❑ sensation that you or things around you are spinning
   ❑ loss of balance when walking, veering to the: ❑ right ❑ left
   ❑ headache
   ❑ nausea or vomiting
   ❑ fullness or pressure in ears or head
   ❑ increased sensitivity of the ears to loud or sharp noise

2. Is the dizziness: ❑ constant ❑ periodic attacks
   *If periodic, how frequently do attacks occur?*_____
   How long do they last? ❑ seconds ❑ minutes ❑ hours ❑ days

3. When did dizziness first occur? _____

4. Do you have any warning that an attack is about to start? ❑ Yes ❑ No

5. Do they occur at any particular time of day or night? ❑ Yes ❑ No
   If yes, Explain _____

6. Are you completely free of dizziness between attacks? ❑ Yes ❑ No

7. Do you have dizziness when: ❑turning over in bed ❑standing up ❑turning head quickly ❑lying down

8. Please list any possible cause of your dizziness: _____
   _____

Continued on back

9. Please list anything that:
   a. *stops your dizziness or makes it better* _____
   b. *makes the dizziness worse* _____
   c. *triggers an attack* ❑ fatigue ❑ exertion ❑ hunger ❑ menstrual period
      ❑ other _____
10. Have you ever had a head injury?_____ If so, please describe_____
    _____

11. Please indicate whether you have the following and which ear(s) is affected:
    ❑ difficulty in hearing ❑ right ear ❑ left ear ❑ both ears
    ❑ fluctuation in hearing ❑ right ear ❑ left ear ❑ both ears
    If so, does it coincide with dizziness? ❑ Yes ❑ No
    ❑ noise in your ears ❑ right ear ❑ left ear ❑ both ears
    Describe the noise:
    ❑buzzing ❑roaring ❑ringing ❑pulsating ❑other_____
    Does noise change with dizziness? ❑ Yes ❑ No
    If so, how?_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any change in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____
Signature of Patient or Guardian Date

Reviewed with patient

_____ _____
Physician's Signature Date

Physician Notes:

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