WYOMING HEARING CLINIC

Patient Questionnaire for Dizziness

Medical Record Number _____

Name _____ Date of Birth _____ Date _____

Main Occupation _____ Additional Occupation _____

1. When did your **FIRST** episode of dizziness occur? _____
2. What were you doing when you had your **FIRST** dizzy spell? _____
3. How long did your **FIRST** episode last? _____
4. Have subsequent dizzy episodes been as severe as the first? ☐ Yes ☐ No
5. Were you ill during or shortly before (within six weeks) your first dizzy spell? ☐ Yes ☐ No
6. Do you have a history of any of the following?

☐ Seizure disorder	☐ Tuberculosis	☐ Syphilis
☐ Lower back pain	☐ Neck pain	☐ Arrhythmia
☐ Neck injury/surgery	☐ Diabetes	☐ Low blood sugar
☐ Knee injury/surgery	☐ Headaches	☐ Elevated cholesterol
☐ Back injury/surgery	☐ Migraines	☐ Heart attack/surgery
☐ Hip injury/surgery	☐ Arthritis	☐ Hole in eardrum
☐ Loss of feeling in feet or legs	☐ Stroke	☐ High blood pressure
☐ Major head trauma (involving loss of consciousness)	☐ Ear surgery	☐ Heart disease
	☐ Anxiety	☐ Thyroid disorder
☐ Infections requiring hospitalization	☐ Panic attacks	
☐ Eye problems/injury/surgery	☐ Depression	

7. How would you describe your dizziness?

☐ Lightheadedness	☐ Unsteadiness
☐ Spinning	☐ Swimming, floating or motion sensation

8. Do you have any of the following symptoms during your dizzy spell?

☐ Nausea				
☐ Vomiting				
☐ Ear pressure	☐ Left	☐ Right	☐ Both	
☐ Ear noise (ringing)	☐ Left	☐ Right	☐ Both	
☐ Hearing loss	☐ Left	☐ Right	☐ Both	
☐ Ear pain	☐ Left	☐ Right	☐ Both	
☐ Ear drainage	☐ Left	☐ Right	☐ Both	
☐ Auras (warning symptoms)				
☐ Loss of consciousness				
☐ Headache				
☐ Double vision				
☐ Falling towards	☐ Left	☐ Right	☐ Forwards	☐ Backwards
☐ Numbness	☐ Face	☐ Arms	☐ Legs	☐ Other
☐ Weakness	☐ Face	☐ Arms	☐ Legs	☐ Other
☐ Difficulty with speech				
☐ Difficulty with swallowing				

9. Does anything improve your dizziness symptoms?_____

_____

10. Is your dizziness constant (continuous day and night)? ☐ Yes ☐ No

11. Does your dizziness come in attacks or waves? (if no, skip to next question) ☐ Yes ☐ No

a. How long does a typical attack last?

☐ A split second
☐ Less than one minute
☐ Several minutes
☐ One to eight hours
☐ More than eight hours

b. How often are your attacks on the average?

☐ Many times per day
☐ Everyday
☐ One or more per week
☐ At least one each month
☐ One every few months
☐ One per year
☐ Less than one per year

c. When was your last attack? _____

d. Do you completely recover in between episodes? ☐ Yes ☐ No

12. What factors trigger or make your dizziness worse?

☐ Rolling over in bed
☐ Bending over
☐ Fatigue
☐ Hunger
☐ Illnesses
☐ Straining or lifting
☐ Walking: ☐ Anytime ☐ In the dark
☐ Standing up
☐ Head motion
☐ Exertion
☐ Emotional stress
☐ Menstruation
☐ Traveling by: ☐ Automobile ☐ Boat ☐ Airplane

13. Which of the following best describes the severity of your dizziness?

☐ I can still go about my daily activities
☐ I need support to stand up
☐ I must sit down until it goes away
☐ I must lie down

14. Which of the following best describes the progress of your dizziness?

☐ Getting better
☐ Getting worse
☐ Staying the same

15. Do you have any blood relatives with any of the following disorders?

☐ Multiple sclerosis
☐ Otosclerosis
☐ Migraine headaches
☐ Nerve tumors
☐ Dizziness
☐ Hearing loss
☐ Meniere's disease

16. Other tests you have had in the past (e.g., blood work, MRI, CT scan, hearing test, neck x-rays, neurology eval) _____

_____

17. Alcohol use? Amount/frequency _____

18. List any medications you are currently taking _____

_____

_____