DIZZINESS QUESTIONNAIRE

Saline Audiology

www.SalineAudiology.com

Complete this form and bring it with you to your appointment.

NAME_____ DATE _____

When did your dizziness first occur?

What were you doing when your dizziness first occurred?

Explain your symptoms without using the word dizzy.

Is your dizziness constant or occur in attacks?

If attacks, how often do they occur?

How long do they last? Any warnings?

Are you completely free of dizziness between attacks?

Which of these best describe your dizziness (check all that apply)?

___swimming sensation in head ___loss of balance when walking ___blacking out ___pressure in head

___objects spinning around you ___lightheadedness ___nausea, vomiting ___headache

___sensation that you are spinning ___loss of consciousness, fainting

Tendency to fall to the (circle all that apply): Right Left Forward Backward

Please list any medications that you take on a regular basis:

_____ _____ _____

_____ _____ _____

_____ _____ _____

List all allergies:

_____ _____ _____

_____ _____ _____

_____ _____ _____

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Please circle "yes" or "no" to the following:

Do you use alcohol?	YES	NO		
Do you smoke?	YES	NO		
Do you ever lose your balance?	YES	NO		
Do you ever feel like you might fall?	YES	NO		
Do you wake up dizzy?	YES	NO		
Are you dizzy when you:				
Turn your head from side to side?	YES	NO		
Turn over in bed?	YES	NO		
Bend over?	YES	NO		
Look up?	YES	NO		
Stand up from sitting?	YES	NO		
Are you a diabetic?	YES	NO		
Do you have heart disease?	YES	NO		
Have you had a stroke?	YES	NO		
When were your eyes last examined?				
Do you wear contacts?	YES	NO		
Do you have double or blurred vision?	YES	NO		
Is it difficult for you to read?	YES	NO		
Do you have headaches?	YES	NO		
Have you ever had a neck or head injury?	YES	NO		
Have you ever had whiplash?	YES	NO		
Have you ever been exposed to toxic chemicals?	YES	NO		
Does your hearing fluctuate?	YES	NO		
Do your ears feel full or have a feeling of pressure?	YES	NO		
Do your ears ring?	YES	NO	Is the ringing constant?	YES NO
Which ear or both?	LEFT	RIGHT	BOTH	
When was your last hearing exam?				
Have you had a CT scan or MRI of the head?	YES	NO	When? _____	
Specialists you have seen regarding this problem?				
Do you or have you ever had motion intolerance?	YES	NO		
How did you feel about carnival rides as a child?				