Dizziness History Questionnaire

This form is to be completed along with the Adult Hearing Health History.
Please bring both to your appointment.

Name: _____ Date of Birth: _____

Have you ever experienced dizziness, lightheadedness, unsteadiness, or vertigo? ☐ YES ☐ NO

Are you feeling dizzy or unsteady today? ☐ YES ☐ NO

How often do you feel dizzy/unsteady? _____

Describe in your own words how your dizziness or unsteadiness feels: _____

Is your dizziness/unsteadiness accompanied by: ☐ nausea ☐ ringing or noises in your ear(s) ☐ hearing loss ☐ visual disturbances ☐ Other: _____

Have you fallen in the last 12 months due to your dizziness/unsteadiness? ☐ YES ☐ NO

If YES, how many falls have you experienced in the last 12 months? _____

If you have fallen, have you been injured? ☐ YES ☐ NO

If YES, please describe your injury: _____

If YES, do you tend to fall to the: ☐ RIGHT ☐ LEFT ☐ BACK ☐ FRONT ☐ NO PATTERN

Do you currently take a Vitamin D supplement? ☐ YES ☐ NO

Do you experience visual difficulties or disturbances? ☐ YES ☐ NO

If YES, please describe:

When did your problem start (date): _____ Was there any related event? ☐ YES ☐ NO

If YES, describe: _____

Was the onset of your problem: ☐ Gradual ☐ Sudden ☐ Other: _____

If your dizziness is not constant, do you have any warning the attacks will occur? ☐ YES ☐ NO

If YES, describe: _____

If YES, do you have dizziness/unsteadiness between attacks? ☐ YES ☐ NO

Does your dizziness/unsteadiness occur with position changes? ☐ YES ☐ NO

If YES, check all that apply:

- ☐ Rolling your body right or left
- ☐ Turning your head left or right
- ☐ Looking up, or head back position
- ☐ Bending over, or head down position
- ☐ Going from lying to sitting position
- ☐ Other: _____

Do you know of anything that makes your dizziness/unsteadiness **better**? ☐ YES ☐ NO

If YES, check all that apply:

- ☐ Not moving your head
- ☐ Rest

(Please Complete Back of Form)

□ Medication: _____

□ Other: _____

Do you know of anything that makes your dizziness/unsteadiness **worse**? □ YES □ NO

If YES, check all that apply:

□ Moving your head

□ Large crowds or busy walkways

□ Other:

□ Riding or driving in the car

□ When you're hungry or haven't eaten

Since it began, is your dizziness/unsteadiness currently: □ Better □ Worse □ Same

Do your symptoms limit your daily activities? □ YES □ NO

Do you have trouble walking in the dark or at dusk? □ YES □ NO

Do you have trouble walking on uneven surfaces (eg. lawn)? □ YES □ NO

When dizzy/unsteady, must you support yourself to stand or walk? □ YES □ NO

Do you have a history of migraine headaches? □ YES □ NO

Have you ever had IV antibiotics or chemotherapy? □ YES □ NO

Have you ever suffered a concussion (head injury)? □ YES □ NO

Do you have trouble sleeping? □ YES □ NO

Do you have pain, fullness, or pressure in your ears? □ YES □ NO

If YES, which ears: □ Right ear □ Left ear □ Both ears

If YES, does it coincide with your dizziness/unsteadiness? □ YES □ NO

Have you experienced any of the following (Indicate if constant or episodic):

Yes	No				Comments
□	□	1. Double/blurred vision or blindness	□ Constant	□ Episodic	_____
□	□	2. Numbness of face or extremities	□ Constant	□ Episodic	_____
□	□	3. Weakness in arms or legs	□ Constant	□ Episodic	_____
□	□	4. Clumsiness in arms or legs	□ Constant	□ Episodic	_____
□	□	5. Confusion or loss of consciousness	□ Constant	□ Episodic	_____
□	□	6. Difficulty with speech or swallowing	□ Constant	□ Episodic	_____

Have you seen other healthcare providers for this problem? □ YES □ NO

If YES, who: □ Primary MD □ Ear, Nose, Throat MD (ENT) □ Neurologist

□ Audiologist □ Cardiologist □ Emergency Room MD □ Physical Therapist

Have you had tests done for this problem elsewhere?

□ YES □ NO □ YES □ NO

ENG/VNG Where: _____ When: _____ Results: _____

MRI/CT Where: _____ When: _____ Results: _____

Hearing tests Where: _____ When: _____ Results: _____

Other: _____

_____ _____

Signature: _____ **Date:** _____