

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: _____

When did your dizziness/imbalance start? _____ Was onset gradual or sudden? Gradual Sudden

Describe in your own words how your symptoms started and how it feels: _____

Do you feel dizzy/off-balance now? YES NO

Do you feel dizzy/off-balance all the time? YES NO If NO, how often? _____

Is it constant or it comes and goes? Constant Comes and goes and lasts: _____

If it comes and goes, do you have any warning it will occur? YES NO

If YES, describe: _____

If YES, are you free of symptoms between attacks? YES NO

nausea ringing or noises in your ear(s) hearing loss

Is your dizziness/imbalance accompanied by: visual disturbances Other: _____

Do you have any neck or back problems/pain/surgeries? YES NO

Does your dizziness/imbalance 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/imbalance **better**? YES NO If YES, check all that apply:

Not moving your head Rest Medication: _____ Other: _____

Do your symptoms limit your daily activities? YES NO If YES, describe: _____

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

Do you have migraine headaches? YES NO If YES, most recent: _____

Have you ever had IV antibiotics or chemotherapy? YES NO If YES, what, why, and when: _____

Have you ever suffered a concussion (head injury)? YES NO If YES, when: _____

Do you have pain, fullness, or pressure in your ears? YES NO If YES, which ear(s): Right Left Both

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

Rev: 4/29/2021

Have you fallen in the last 12 months due to your dizziness/unsteadiness? YES NO
 If YES, how many times in the last 12 months? _____ Were you injured at all? YES NO
 If YES, please describe your injury: _____
 If YES, do you tend to fall to the: Right Left Backwards Front No pattern
 Do you currently take a Vitamin D supplement? YES NO

Have you taken any pain, sleep, anti-dizzy, anti-depressant, anti-anxiety, anti-epileptic medications in the past 24 hours? YES NO

If YES, what medication and why? _____

Have you consumed alcohol in the last 24-hours? YES NO

Do you experience any of the following since your problem started? (Indicate if constant or episodic):

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

Have you seen other healthcare providers for your dizziness/imbalance? 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 your dizziness elsewhere? YES NO

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

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

Hearing tests Where: _____ When: _____ Results: _____

Other: _____

Signature: _____ **Date:** _____

Clinician Notes:
