FAYETTEVILLE OTOLARYNGOLOGY
Ear, Nose & Throat Surgery • Allergy
Advanced Hearing Services

FAYETTEVILLE OTOLARYNGOLOGY
Head & Neck Surgery, P.A.

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Dizziness Questionnaire

Date _____ Patient Name _____ DOB _____ Chart # _____

A) When you are dizzy do you experience any of the following sensations?
Please describe your feelings most accurately by placing a check in the box for YES or NO.

Yes	No	
☐	☐	Lightheadedness?
☐	☐	Swimming sensation in the head?
☐	☐	Blacking out?
☐	☐	Loss of consciousness?
☐	☐	Tendency to fall: to the right?
☐	☐	to the left?
☐	☐	forward?
☐	☐	backward?
☐	☐	Objects spinning or turning around you?
☐	☐	Sensation that you are turning or spinning inside, with outside objects remaining stationary?
☐	☐	Loss of balance when walking: veering to the right?
☐	☐	veering to the left?
☐	☐	Headache?
☐	☐	Nausea or vomiting?
☐	☐	Pressure in the head?
☐	☐	Is your dizziness constant?
☐	☐	Is your dizziness in attacks?
☐	☐	When did the dizziness first occur? _____
☐	☐	If in attacks: How often? _____
☐	☐	How long do they last? _____
☐	☐	Do you have any warning that the attack is about to happen?
☐	☐	Are you completely free of dizziness between attacks?
☐	☐	Does dizziness occur only in certain positions?
☐	☐	Do you have trouble walking in the dark?
☐	☐	When you are dizzy, must you support yourself when standing?
☐	☐	Do you know of any possible cause of your dizziness?
☐	☐	If so explain _____
☐	☐	Do you know of anything that will: stop your dizziness or make it better?
☐	☐	make your dizziness worse?
☐	☐	precipitate an attack?
☐	☐	Were you exposed to any irritating fumes, paints, etc., at the onset of your dizziness?
☐	☐	Do you have any allergies?
☐	☐	Have you ever injured your head?
☐	☐	If so, were you unconscious?
☐	☐	Do you take any medications regularly? If so, what _____
☐	☐	Do you use tobacco in any form? If so, how much _____
☐	☐	Do you drink alcohol?
☐	☐	Have you ever had ear surgery?

B) Do you have any of the following symptoms?
Place a check in the box for YES or NO and circle the ear involved.

Yes	No				
☐	☐	Difficulty in hearing?	Both ears	Right	Left
☐	☐	When did it start?			
☐	☐	Is it getting worse?			
☐	☐	Difficulty in hearing?	Both ears	Right	Left
☐	☐	Describe the noise			
☐	☐	Does the noise change with the dizziness? If so, explain			
☐	☐	Does anything stop the noise or make it better?			
☐	☐	Is there fullness or stuffiness in your ears?	Both ears	Right	Left
☐	☐	If so, does this change when you are dizzy?			
☐	☐	Is there pain in your ears?	Both ears	Right	Left
☐	☐	Discharge from your ears?	Both ears	Right	Left

C) Have you ever experienced any of the following symptoms?
Place a check in the box for YES or NO and circle if constant or in episodes.

Yes	No			
☐	☐	Double vision?	Constant	Episodes
☐	☐	Numbness of face or extremities?	Constant	Episodes
☐	☐	Blurred vision or blindness?	Constant	Episodes
☐	☐	Weakness in arms or legs?	Constant	Episodes
☐	☐	Clumsiness in arms or legs?	Constant	Episodes
☐	☐	Confusion or loss of consciousness?	Constant	Episodes
☐	☐	Difficulty with speech?	Constant	Episodes
☐	☐	Difficulty with swallowing?	Constant	Episodes
☐	☐	Tingling around the mouth?	Constant	Episodes
☐	☐	Spots before your eyes?	Constant	Episodes
☐	☐	Do you get dizzy after exertion or overwork?		
☐	☐	Did you get new glasses recently?		
☐	☐	Do you tend to get upset easily?		
☐	☐	Do you get dizzy when you have not eaten for a long time?		
☐	☐	Is your dizziness connected with your menstrual period?		
☐	☐	Have you ever had a neck injury?		

D) Please let us know of anything else that you feel could help, that we have not asked you.

Patient Name _____ Chart # _____