Rehder Balance & Hearing Clinic

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Dizziness Questionnaire

Patient Name: _____ **DOB:** _____ **Date:** _____

Please respond to the following (circle one)			
I get dizzy when I change the position of my head and/or body.	Never	Sometimes	Always
I get dizzy when I turn over in bed.	Never	Sometimes	Always
I get dizzy when I move from a sitting to a standing position.	Never	Sometimes	Always
I get dizzy when I tilt my head upward.	Never	Sometimes	Always
I get dizzy for a few seconds if I turn my head quickly left or right.	Never	Sometimes	Always
I get dizzy spells lasting less than one minute.	Never	Sometimes	Always

IF THE SITUATIONS ABOVE DO NOT DESCRIBE YOUR BALANCE/DIZZINESS CONCERNS – PLEASE COMPLETE THE REMAINDER OF THESE QUESTIONS.

1. Briefly describe what you are experiencing without using the word "dizzy": _____

_____

2. "Dizziness" is a generic term that encompasses many symptoms. Which of the following best describes your symptoms?
- Yes No *Vertigo*: The sensation of motion or movement when none is present (i.e.: spinning, turning, tipping, rocking)
- Yes No *Syncope:* The feeling you are going to black out or lose consciousness
- Yes No *Unsteadiness:* Loss of "sure footedness" or balance when walking
- Yes No *Lightheadedness*: A vague sensation of disorientation

3. When did your symptoms begin? _____

4. What were you doing when it began? _____

5. How long do the symptoms last? Seconds Minutes Hours Days Constant

6. How often do they occur? Daily Every few days Every few months Every few years

7. Do you experience: (circle all that apply) Nausea Vomiting Ringing in your ears Hearing Loss

8. Do your symptoms come in attacks? Yes No

9. Are you symptom free between attacks? Yes No

10. When was your LAST attack? _____ Describe it. _____

11. Are your symptoms getting Better Worse Same Fluctuating

12. Have you had physical therapy for your dizziness or balance problem? Yes No

What medications have you taken for your dizziness/balance problems?

Name	Dosage	# Times/day	Did it help?
			Yes No
			Yes No
** Are you ***Currently*** taking any medications for dizziness / balance?			Yes No

Ear and Hearing History

1. Rate your overall hearing ability: (no problems) 0 1 2 3 4 5 6 7 8 9 10 (extreme difficulty)

2. Yes No My hearing loss was sudden.

3. Yes No I currently wear hearing aids. Both Right Left

4. Yes No I have ringing in your ears. Both Right Left

5. Yes No I have pressure / fullness in my ears. Both Right Left

6. Yes No My hearing fluctuates during dizzy episodes? Both Right Left

Medical History

Yes No Heart attack When? _____ Yes No Hip problems. Surgery? _____

Yes No Cardiac Surgery. When?_____
Yes No Stroke
Yes No TIAs
Yes No Ear surgery or disease. What?_____
Yes No Diabetes
Yes No Migraines
Yes No Siezures
Yes No Multiple sclerosis
Yes No Cancer treatment. (Radiation, chemotherapy)
Yes No Head trauma. When? _____

Yes No Knee problems. Surgery?_____
Yes No Back problems. Surgery?_____
Yes No Neck problems. Surgery?_____
Yes No Foot problems?_____
Yes No Depression
Yes No Anxiety
Yes No Other health conditions? Please list:
_____
_____
_____

Medications: Please list all current medications including hormones, birth control pills, vitamins, over-the-counter, etc.

Name	Dosage	# Times per day

Previous Medical Tests:

Have you had any of the following tests in the past?			When?	Results?
Yes	No	Carotid Artery Doppler Flow Study		
Yes	No	MRI of brain With Contrast? Yes / No		
Yes	No	MRA of brain (blood flow study)		
Yes	No	CT Scan of brain		
Yes	No	Heart testing (EKG, echo, stress test)		
Yes	No	Complete physical including bloodwork		
Yes	No	Hearing evaluation		

Thank you for taking the time to <u>fully complete</u> this questionnaire. Remember to bring it with you to your appointment.