Blue Ridge Hearing and Balance Clinic
Dizziness History Questionnaire

Name: ___________________________ Age: ________ Date: ________________

WHEN was the first time ever in your life you had dizziness? ________________________________

WHAT were the circumstances? __________________________________________________________

WHEN was the last time you experienced dizziness? ________________________________

WHAT were the circumstances? __________________________________________________________

Currently, my dizziness…

__ is constant.
__ is always there, but changes in intensity.
__ comes and goes.

If comes and goes:
How long does it typically last? ___ seconds / minutes / hours (Circle ONE)
How often does it typically occur? ___ times per: hour / day / week / month / year

My dizziness mostly consists of…(Check ALL that apply)

__ spells of spinning with nausea.
__ off-balance sensation without dizziness.
__ a light-headed or near faint sensation.
__ other. Please explain _______________________________________________________________

Between episodes I feel…(Check ONE)

__ dizzy or off balance all the time.
__ normal.
__ other. Please explain _______________________________________________________________

My episodes occur…(Check ALL that apply)

__ spontaneously. Nothing I do seems to bring them on or turn them off.
__ only when standing or walking.
__ in relation to any head motion.
__ in relation to only certain head positions. Please describe _________________________________

When I roll over in bed…(Check ONE)

__ nothing unusual happens.
__ the room seems to spin sometimes.
__ the room spins every time.

Is there anything that you can do to make you dizziness go away? (sit, lay down, close eyes…) 
Please explain: ______________________________________________________________________
__________________________________________________________________________________
Circle all that apply:
I have hearing difficulty ………………………..Right…..Left…..Both
I have ringing or other sounds ……………………Right…..Left…..Both
I have fullness ………………………………………Right…..Left…..Both
I have had ear surgery ……………………………Right…..Left…..Both

Circle YES or NO
Did you have cold, flu or virus type symptoms shortly before the onset of your dizziness? YES / NO
Did you cough, lift, sneeze, fly in a plane, swim under water or have a head trauma shortly before the onset of your dizziness? YES / NO
If you had head trauma prior to your dizziness, did you lose consciousness completely? YES / NO
Were you exposed to any irritating fumes, paints, etc. at the onset of your dizziness? YES / NO
Do you get dizzy when you have not eaten for a long time? YES / NO
I your dizziness connected with your menstrual period? YES / NO
Did you get new glasses recently? YES / NO
I consider myself to be an anxious or tense type of person… YES / NO
I am under a great deal of stress… YES / NO

In the past year I have had…(Check ALL that apply)
- loss of consciousness
- seizures or convulsions
- slurring of speech
- difficulty swallowing
- weakness in one hand, arm or leg
- double vision
- spots before the eyes

I have or have had…(Check ALL that apply)
- Diabetes
- High blood pressure
- Arthritis
- Irregular heartbeat

Please check below for any MEDICATIONS you have tried FOR DIZZINESS or are currently taking:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Taken in past</th>
<th>Taking now</th>
<th>Helps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antivert (Meclizine)</td>
<td></td>
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<tr>
<td>Valium (Diazepam)</td>
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<tr>
<td>Dyazide “water pills”</td>
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</tbody>
</table>

Have you ever been previously evaluated for dizziness? ______________________________________