DIZZY EVALUATION

Name: ______________________________Date:_________________

When did your dizziness first occur? ____

A. Circle YES or NO and Specify if indicated

1. My dizziness is constant	Yes	No
2. My dizziness comes in attacks. If in attacks, how often_______________ How long do they last? ______________________________________	Yes	No
3. Can you tell when an attack is about to start?	Yes	No
4. Does change of position make you dizzy?	Yes	No
5. Do you have trouble walking in the dark?	Yes	No
6. When you are dizzy, can you stand up unsupported?	Yes	No
7. Are you completely free of dizziness between attacks?	Yes	No
8. Do you know the possible cause of your dizziness? If yes, what? ____	Yes	No
9. Do you know anything that will:		
• Cause an attack	Yes	No
• Stop your dizziness or make it better?	Yes	No
• Make your dizziness worse?	Yes	No
10. Were you exposed to any irritating fumes or gases?	Yes	No
11. Do you have any allergies?	Yes	No
12. Did you ever injure your head? If yes, were you unconscious? ________	Yes	No
13. Do you take any medications regularly? If yes, what? _______________ ____	Yes	No
14. Do you smoke? If yes, how much? ______________________________	Yes	No

B. When dizzy, do you experience any of the following?

1. Lightheadedness	Yes	No
2. Swimming sensation in head	Yes	No
3. Objects spinning around you	Yes	No
4. Sensation that you are spinning, with outside objects remaining stationary	Yes	No
5. Tendency to fall – which way ____________________________________	Yes	No
6. Loss of balance when walking – to the right or left ___________________	Yes	No
7. Headache	Yes	No
8. Nausea or vomiting	Yes	No
9. Pressure in the head	Yes	No

C. Do you experience any of the following?

1. Difficulty in hearing	Yes	No	Both ears	Right	Left
2. Noise in your ears – If yes, describe: ____	Yes	No	Both Ears	Right	Left
3. Fullness in your ears	Yes	No	Both Ears	Right	Left
4. Pain in your ears	Yes	No	Both Ears	Right	Left
5. Discharge from your ears	Yes	No	Both Ears	Right	Left

D. Do you experience any of the following?

1. Double Vision	Yes	No	Constant	In episodes
2. Numbness of face or extremities	Yes	No	Constant	In episodes
3. Blurred Vision or blindness	Yes	No	Constant	In episodes
4. Weakness in arms or legs	Yes	No	Constant	In episodes
5. Clumsiness in arms or legs	Yes	No	Constant	In episodes
6. Confusion or loss of consciousness	Yes	No	Constant	In episodes
7. Difficulty with speech	Yes	No	Constant	In episodes
8. Difficulty with swallowing	Yes	No	Constant	In episodes

E. Family History

1. Do you or a member of your family have a hearing loss? If yes, what type? Yes No

   ____

2. Do you or a member or your family have dizzy problems? If yes, what is the cause? Yes No

   ____

3. Do you or a member of your family have any of the following:
   - Meniere's Disease Yes No
   - Acoustic Neuroma Yes No
   - Otosclerosis Yes No
   - Middle Ear Fluid Yes No
   - Perforated Eardrum Yes No
   - Multiple Sclerosis Yes No
   - Hearing Loss due to age Yes No
   - Sudden Nerve Hearing loss Yes No
   - Other ____

F. Head Injury

1. Have you ever been knocked unconscious? If yes, How? ____________________ Yes No

   ____

2. Do you have or have you ever had any of the following?
   - Whiplash Yes No
   - Skull Fracture Yes No
   - Neck Injury Yes No
   - Back Injury Yes No
   - Eye Problems Yes No
   - Other____

G. Ototoxic Drug History

1. Have you taken any of the following? If yes, list quantity and duration
   - Neomycin Quantity ______________How Long ______________ Yes No
   - Streptomycin Quantity ______________How Long ______________ Yes No
   - Kanamycin Quantity ______________How Long ______________ Yes No
   - Quinine Quantity ______________How Long ______________ Yes No
   - Aspirin Quantity ______________How Long ______________ Yes No
   - Diuretics Quantity ______________How Long ______________ Yes No

- Arthritic Medications Quantity _______________How Long _______________ Yes No
- Other Quantity _______________How Long _______________ Yes No

H. Ear Operations/Other

1. Have you ever had any of the following?
   - Tubes in the ears Yes No
   - Mastoid Surgery Yes No
   - Eardrum Surgery Yes No
   - Stapedectomy Yes No
   - Neck Surgery Yes No
   - Back Surgery Yes No
   - Discharge from the ear Yes No
   - Head Pain Yes No
   - Facial Pain Yes No