

The patient history and a description of the symptoms are extremely important in making a correct diagnosis. **Please answer yes or no, circle the appropriate answer, or fill in the appropriate blanks for EACH QUESTION.**

1. Describe your dizziness symptoms.
 Yes No a) Spinning vertigo
 Yes No b) Lightheadedness/wooziness
 Yes No c) Imbalance/trouble walking/trouble standing
 Yes No d) Veering or falling: *To the right* *To the left* *Forward* *Backward*
 Yes No e) Delayed focusing of visual fields
 Yes No f) Visual blurring during head motion
 Yes No g) Blacking out (If yes, do you lose consciousness? Yes No)

Duration, Timing, Context and Severity

2. When was your first dizzy episode? (date) _____
3. When did the most recent dizziness episode begin? (Date) _____
4. Is the dizziness constant or recurrent? Constant Recurrent Constant when walking
5. How long do the episodes last? _____ (circle) ... *Seconds Minutes Hours Days*
6. How often do the episodes occur? _____ per (circle) ... *Day Week Month Year*
7. Rate the severity of the dizziness. (10 is the MOST severe) _____
8. Is the dizziness: (Circle) *Improving Getting worse The same*

Modifying Factors

9. Yes No Is the dizziness triggered by rapid movements of the head or body? (If yes, circle those that apply)

All rapid head movements Lying down Looking up Rising or bending over Getting out of bed

Turning head to the right Turning head to the left Rolling right in bed Rolling left in bed
10. Do any of the following trigger the dizziness? (If yes, circle those that apply)

Caffeine Salt Other dietary items Stress/fatigue Emotional change Allergies Other _____
11. What, if anything, makes your dizziness better? (list) _____
12. Yes No Have you experienced motion sickness?
13. Yes No Do you have problems walking in the dark?
14. Yes No Do you require assistance when walking? Sometimes/Always (Circle those that apply) *Companion Cane Walker*
15. Yes No Did you suffer a cold, flu, or other infectious symptoms at the time your dizziness began?
16. Yes No Have you suffered: (Circle those that apply) *Head trauma Concussion Stroke TIA (mini-stroke)*

Associated Signs and Symptoms

17. Yes No Do you experience increased ear ringing with your dizzy spells? Which ear? Right Left
18. Yes No Do you suffer increased hearing loss with your dizzy spells? Which ear? Right Left
19. Yes No Do you suffer increased pressure in your ears with your dizzy spells? ... Which ear? Right Left
20. Yes No Do you experience nausea or vomiting with the dizzy spells? (Circle) *Nausea Vomiting*
21. Yes No Have you experienced falls?
22. Yes No Do you suffer from recurrent headaches or pressure in the head? Location: _____
23. Yes No Do the headaches occur at the same time and the dizziness?
24. Are your headaches associated with any of the following symptoms? (Please circle all that apply)

Throbbing head pain Moderate or severe head pain Visual spots/ Squiggly lines

Sensitivity to bright lights Sensitivity to loud noises Nausea Vomiting

25. Yes No Have you seen any other doctors for evaluation of this problem? (Provide name) _____
26. Yes No Have you been diagnosed with a specific ear or balance problem? _____
27. Yes No Have you had other tests completed? (If yes, circle all those that apply.)

Hearing Test Vestibular/Balance testing MRI scan of the brain CT scan of the brain Carotid ultrasound Heart Testing

Name (print): _____ Signature: _____ Date: _____