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….(Check ONE)
__ is constant.
__ is always there, but changes in intensity.
__ comes and goes.

If it comes and goes:
How long does it typically last?__ seconds / minutes / hours (Circle ONE)

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 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 your 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 a 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, 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
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 in swallowing
__ weakness in one hand, arm or leg
__ double vision
__ spots before the eyes
__ occasional loss of vision
__ severe pounding headache or migraine
__ palpitations of the heartbeat
__ tingling around mouth
__ tendency to fall
__ loss of balance when walking

I have or have had… (Check ALL that apply)

__ Diabetes
__ High blood pressure
__ Arthritis
__ Irregular heartbeat
__ Stroke
__ Migraine Headaches
__ A neck and/or back injury
__ Allergies

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

	Taken in past	Taking now	Helps
Antivert	___	___	___
Valium	___	___	___
Dyazide "water pills"	___	___	___
Other _____	___	___	___

Have you ever been previously evaluated for dizziness?

_____
_____