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_____ — Yes No
   How long do they last? _____
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? — Yes No
   If yes, what? _____
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