Med Center Health®

ENT

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

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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