Dizziness History Questionnaire

Please fill out the questionnaire and bring to your VNG appointment.

Name:_____ Age:_____ DOB:_____

WHEN was the first time you ever had dizziness? _____

WHAT were the circumstances? _____

_____

WHEN was the last time you experienced dizziness? _____

WHAT were the circumstances? _____

_____

CURRENTLY, MY DIZZINESS…

- ☐ is constant
- ☐ is always there, but changes in intensity
- ☐ comes in episodes

IF COMES AND GOES:

How long does it typically last? _____ ☐ seconds ☐ minutes ☐ hours

How often does it typically occur? _____ times per: ☐ hour ☐ day ☐ week ☐ month ☐ year

MY DIZZINESS MOSTLY CONSISTS OF… (Check ALL that apply)

- ☐ spells of spinning
- ☐ nausea and/or vomiting
- ☐ off-balance sensation
- ☐ light-headed/near faint sensation
- ☐ other. Please explain _____

BETWEEN EPISODES I FEEL … (Check ALL that apply)

- ☐ dizzy or off balance all or some of 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 up or walking
- ☐ In relation to any head motion
- ☐ Only in certain head positions. Please describe _____

WHEN I ROLL OVER/LAY DOWN IN BED:

- ☐ Nothing unusual happens
- ☐ The room seems to spin sometimes.

IF YOU HAVE DIZZINESS IN BED…

Which direction are you rolling? ☐ right ☐ left ☐ straight back ☐ unknown ☐ other

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IS THERE ANYTHING THAT YOU CAN DO TO MAKE YOUR DIZZINESS GO AWAY? (Stay still, close eyes…)

Please explain: _____

_____

CHECK ALL THAT APPLY:

I have hearing difficulty. ☐*Right* ☐*Left* ☐*Both* I have ringing, roaring, or other sounds. ☐*Right* ☐*Left* ☐*Both*

I have ear fullness. ☐*Right* ☐*Left* ☐ *Both* I have had ear surgery. ☐ *Right* ☐*Left* ☐*Both*

If you answered yes to any of the above, did this happen at the same time as your dizziness? Or is it pre-existing? Please explain: _____

CHECK YES OR NO

- Did you have cold, flu, or virus symptoms shortly before onset of your dizziness? …… ☐YES ☐NO
- Did you cough, lift, sneeze, fly in a plane, swim under water, or have a head trauma shortly before the onset of your dizziness? …….. ☐ YES ☐ NO
- Were you exposed to any irritation 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
- Is your dizziness connected with your menstrual period? …… ☐ YES ☐ NO
- Did you get new glasses recently? …… ☐ YES ☐ NO
- I consider myself to be an anxious or tense type of person…… ☐ YES ☐ NO

IN THE PAST YEAR I HAVE HAD … (Check ALL that apply)

☐ loss of consciousness ☐ occasional loss of vision ☐ seizures of convulsions

☐ severe pounding headache or migraine ☐ slurring of speech ☐ difficulty swallowing

☐ palpitations of heartbeat ☐ weakness in one hand, arm, leg, side of body ☐ double vision

☐ tingling around mouth ☐ tendency to fall ☐ spots before eyes ☐ loss of balance when walking

I HAVE OR HAVE HAD … (Check ALL that apply)

☐ Diabetes ☐ Stroke ☐ High blood pressure ☐ Migraine headaches ☐ Arthritis ☐ Allergies

☐ Irregular heartbeat ☐ A neck and/or back problem/injury Please explain: _____

PLEASE CHECK BELOW FOR ANY MEDICATIONS YOU HAVE TRIED FOR DIZZINESS OR ARE CURRENTLY TAKING:

	Taking in Past	Taking now	Helps
Antivert (Meclizine)	_____	_____	_____
Valium (Diazepam)	_____	_____	_____
Dyazide “water pills”	_____	_____	_____

HAVE YOU EVER BEEN PREVIOUSLY EVALUATED FOR DIZZINESSS? (WHERE? WHEN? PLEASE EXPLAIN)

_____

_____