Manchester Ear, Nose & Throat Center, LLC

2800 Tamarack Ave. Suite 102 South Windsor CT 06074

DIZZINESS QUESTIONNAIRE

Name: ______________________________ Date: ________________

Please answer these questions to the best of your ability. Please give necessary details for yes answers. If you do not have dizziness, answer all questions to the best of your ability.

1. If you have any of these symptoms, please describe them.

a. Trouble with walking or balance.

b. Sense of spinning, tumbling, cart wheeling.

c. Sense of tilt, being off balance, rocking.

d. Nausea, vomiting.

e. Double or blurred or jumping of vision or flashes of light.

f. Moving, tilt or rotation of the world.

2. If you have dizziness or vertigo or imbalance, is it affected or brought on by:

	YES	NO
Changes in position of the head/body (ex:turning over in bed)	☐	☐
Shopping malls, narrow or wide open spaces	☐	☐
Rapid head movements	☐	☐
Tunnels, bridges, supermarkets	☐	☐
Standing up	☐	☐
Exercise	☐	☐
Walking in a dark room	☐	☐
Heat, hot or cold showers	☐	☐
Elevators, escalators	☐	☐
Time of day	☐	☐
Climbing stairs or ladders	☐	☐
Swallowing	☐	☐
Airplane, boat or car travel	☐	☐
Depression, anxiety, nerves or stress	☐	☐
Loud noises	☐	☐
Alcohol	☐	☐
Cough, sneeze, strain, or laugh	☐	☐
Menstrual periods	☐	☐
Movement of objects in the environment	☐	☐
Foods: eating/not eating, salt, sugar, Monosodium Glutamate (MSG)	☐	☐
Fluorescent lights	☐	☐
Walking on uneven surfaces	☐	☐

3. Have you had:

	YES	NO
Infection of ears	☐	☐
Inner ear disease (ex: labyrinthitis)	☐	☐
Pain, pins/needles, numbness/paralysis of face	☐	☐
Ringing in ear, steady or pulsating	☐	☐
Pain, fullness or pressure in ear	☐	☐
Trouble chewing or swallowing or speaking	☐	☐
Difficulty with your hearing	☐	☐
Crossed eyes, lazy eye	☐	☐
Does cough, sneeze, strain, or laughing bring on dizziness, pain or headache	☐	☐
Poor vision in one eye (amblyopia)	☐	☐
Any problems brought on by airplane travel, underwater diving	☐	☐
Tremor or shakiness, stiffness, incoordination	☐	☐
Sweating, cold feelings	☐	☐
Do or did you have motion sickness (car or boat)	☐	☐
Palpitations (abnormal or fast beating) of the heart	☐	☐

4. Recently (within the last year) have you noted:

	YES	NO
Strength or energy change	☐	☐
Weight or appetite change	☐	☐
Skin rash	☐	☐
Pins and needles, numbness	☐	☐
Muscle or joint aches	☐	☐
Diarrhea or constipation	☐	☐
Fevers or swollen glands	☐	☐
Bladder problems	☐	☐
Problems with sexual function	☐	☐

5. Questions about your habits:

	YES	NO
Do or did you use alcohol?	☐	☐
How much? ______________________		
Do or did you ever smoke?	☐	☐
Did you ever use intravenous drugs?	☐	☐
Did you ever use LSD?	☐	☐
Do you use caffeine?	☐	☐
Do you salt your food?	☐	☐

6. Injuries:

	YES	NO	
Ears?	☐	☐	______________________
Eyes?	☐	☐	______________________
Head?	☐	☐	______________________

7. Past or present health has been affected by:

	YES	NO
Heart problems	☐	☐
Diabetes	☐	☐
Low sugar (hypoglycemia)	☐	☐
Thyroid disorders	☐	☐
Treatment by a psychiatrist or counselor	☐	☐
Depression or unusual amounts of stress	☐	☐
High cholesterol	☐	☐
High or low blood pressure	☐	☐
Pain in back of jaw (TMJ), grinding	☐	☐
Loss of consciousness (faints)	☐	☐
Seizures or convulsions	☐	☐
Blood diseases, anemia	☐	☐
Skin diseases	☐	☐
Arthritis	☐	☐
Any other major illnesses or other surgery	☐	☐

8. Are there any family members with:

	YES	NO
Migraine headaches	☐	☐
Meniere's syndrome	☐	☐
Hearing loss	☐	☐
Vertigo or dizziness	☐	☐
Balance problems	☐	☐
Convulsions or seizures	☐	☐
Diabetes	☐	☐
Cancer or brain tumors	☐	☐
Stroke	☐	☐
Heart disease or high blood pressure	☐	☐
Any diseases that run in the family	☐	☐
Health of brothers and sisters	☐	☐
Health of children	☐	☐
Health of parents	☐	☐

If your parents, brothers, sisters or any children had illnesses, at what age and from what cause?

____

9. What are your current medications, including hormones, birth control pills, vitamins, etc.?

Medication Name ______________________ Amount/Day ______________

Medication Name ______________________ Amount/Day ______________

Medication Name ______________________ Amount/Day ______________

Medication Name ______________________ Amount/Day ______________

Medication Name ______________________ Amount/Day ______________

Medication Name ______________________ Amount/Day ______________

Medication Name ______________________ Amount/Day ______________

10. What medications have you taken for your dizziness? What dosage and for how long?

11. Have you had a:

	YES	NO
Hearing test	☐	☐
Evaluation by an ear doctor	☐	☐
Balance test (water or air in ear)	☐	☐
MRI and/or CT scan of the head or neck	☐	☐
Arteriogram (blood vessel x-ray)	☐	☐
BAER (evoked potentials)	☐	☐
Sinus x-rays	☐	☐
Neck x-ray	☐	☐
Myelogram	☐	☐
Lumbar puncture (spinal fluid examination)	☐	☐
EEG (Brain Wave)	☐	☐
Recent General Medical Checkup?	☐	☐
Blood work	☐	☐
Urinalysis	☐	☐
Chest x-ray	☐	☐
Mammogram	☐	☐
GYN exam	☐	☐
Holter monitor	☐	☐
Electrocardiogram	☐	☐
Lyme test	☐	☐
Glucose tolerance test	☐	☐
B12	☐	☐
Thyroid	☐	☐

Explain any abnormal results: