ENT ASSOCIATES OF NORTHERN COLORADO

Dizziness Symptom Questionnaire

Patient Name: _____ **Age**:_____ **Date**: _____

Please answer the following questions carefully.

1. How long have you been dizzy?	
2. Is it constant or in attacks?	Constant / Attacks How frequent?
3. Is there a symptom free period between attacks?	Yes / No Specify:
4. What brings on the dizziness?	
5. Is the dizziness affected by positional changes?	Yes / No Specify:
6. Do **you** or the **room** spin when you are dizzy; how long?	No spinning / I spin / The room spins How long?
8. Are you lightheaded today?	Yes / No
9. When dizzy, do you feel you may black out; have you blacked out?	Yes / No Yes I have blacked out / No I have not blacked out
11. Do you have nausea and/or vomiting?	Yes / No Nausea / Vomiting / Both
12. Does anything relieve the dizziness?	Yes / No Specify:
13. Do you know of any possible cause for your dizziness?	Yes / No Specify:
14. Do you know when an attack is coming and how?	Yes / No Specify:
15. Any previous ear operations?	Yes / No What operation? When was the operation?
16. Do you have ear pressure; does it come and go?	Yes / No Specify:
17. Do your ears ring or buzz; does it come and go?	Yes / No Describe your symptoms: Left / Right / Both
18. Do you have any hearing loss; does it come and go?	Yes / No
19. Does either or both of you ears drain?	Right / Left / Both
20. Have you ever had any head, neck, whiplash or ear injury?	Yes / No Specify:
21. Were you ever exposed to any irritating fumes, paints, etc. at the onset of dizziness?	Yes / No Specify:
22. Have you taken drugs or antibiotics that may have affected your hearing or balance?	Yes / No Specify:
23. Have you had a cold or the flu in the last six weeks?	Yes / No
24. Have you had any slurred or difficult speech?	Yes / No Specify:
25. Have you had double or blurred vision?	Yes / No Specify:
26. Have you had numbness or weakness of the face or extremities?	Yes / No Specify:
27. Have you had confusion or loss of consciousness?	Yes / No Specify:
28. Have you had a tendency to fall?	Yes / No Specify:
29. Have you ever smoked; how much?	Currently / Former-Quit:_____ / Never How Much:_____

BLOOD PRESSURE: /