Washington University School of Medicine
Department of Otolaryngology-Head and Neck Surgery
Dizziness and Balance Center

Patient Name:__________________________ D.O.B:___/___/___ Sex: M___F___ Date: ___/___/___

The following questions refer to your feeling of dizziness. Please answer them as "yes" or "no" and fill in all blanks.

Please describe in your own words, the sensation you feel without using the word "dizzy":

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I. Do you ever have any of the following sensations?

Yes Spinning in circles No
Yes Falling to one side No
Yes World spinning around you No

II. The following refer to a typical dizzy spells:

Yes Do your dizzy spells come in attacks? No
How often? ___________________________
How long is the attack? ________________
Date of first spell? _____________________
Yes Are you free from dizziness between attacks? No
Yes Does your hearing change with an attack? No
Yes Are you dizzy mainly when you sit or stand up quickly? No
Yes Are you dizzier in certain positions? No
Which position? ______________________________
Yes Are you nauseated during an attack? No
Yes Are you dizzy even when lying down? No
Yes Have you had a recent cold or flu preceding recent dizzy spells? No
Yes Have you had fullness, pressure, or ringing in your ears? No
Yes Have you had pain or discharge in your ear of recent onset? No
Yes Have you had trouble walking in the dark? No
Yes Are you better if you sit or lie perfectly still? No
Yes Do loud sounds make you dizzy? No

III. The following refer to other sensations you may have:

Yes Do you black out or faint when dizzy? No
Have you had:
Yes Severe or recurrent headaches? No
Yes Light sensitivity with your headaches or dizziness? No
Yes Any double or blurry vision? No
Yes Numbness in your face or extremities? No
Yes Weakness or clumsiness in arms, legs? No
Yes Slurred or difficult speech? No
Yes Difficulty swallowing? No
Yes Tingling around your mouth? No
Yes Spots before your eyes? No
Yes Jerking of arms or legs? No
Yes Seizures? No
Yes Confusion or memory loss? No
Yes Recent head trauma? (If yes, please explain) No

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IV. The following refer to your hearing. Indicate which side has been affected:

Yes	Difficulty hearing in one ear?	Left	Right	Both	No
Yes	Ringing in one ear?	Left	Right	Both	No
Yes	Fullness in one ear?	Left	Right	Both	No
Yes	Change in hearing when dizzy?				No
	Have you had any of the following?				
Yes	Pain in ears?	Left	Right	Both	No
Yes	Discharge from ears?	Left	Right	Both	No
Yes	Hearing change?				No
Yes	Better?	Left	Right	Both	No
Yes	Worse?	Left	Right	Both	No
Yes	Exposure to loud noises?				No
Yes	Previous ear infections?				No
Yes	Trauma to your ear(s)?				No
Yes	Previous ear surgery?				No
	What? ____________________				No
Yes	Family history of deafness?				No

V. The following refer to habits and lifestyle:

Yes	Is there added stress to your life recently?		No
Yes	Are you dizzy or unsteady constantly?		No
	Is your dizziness related to:		
Yes	Moments of stress?		No
Yes	Menstrual period?		No
Yes	Overwork or exertion?		No
Yes	Do you feel lightheaded or have a swimming sensation when you are dizzy?		No
Yes	Do you find yourself breathing faster or deeper when excited or dizzy?		No
Yes	Did you recently change eyeglasses?		No
Yes	Have you ever had weakness or faintness a few hours after eating?		No
Yes	Do you drink coffee?	How much? ________________	No
Yes	Do you drink tea?	How much? ________________	No
Yes	Do you drink soft drinks?	How much? ________________	No
Yes	Do you drink alcohol?	How much? ________________	No
Yes	Do you smoke? What?__________	How much? ________________	No

Past Medical History:

Please list your current medical problems and length of illness: ______________________________

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Please list all surgery performed and approximate dates: ______________________________

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Please list all allergies (including drugs) and reaction: ______________________________

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Please list all medicines you currently take (including pain medicine, non-prescription medicine, nerve pills, sleeping pills, or birth control pills). ______________________________

Have you had any previous testing (hearing, x-rays, head scans, etc.)? ______________________________

Family History:
Any family history of:

Yes	Migraine?	No
Yes	High blood pressure?	No
Yes	Low blood pressure?	No
Yes	Diabetes?	No
Yes	Low blood sugar?	No
Yes	Thyroid disease?	No
Yes	Asthma?	No

Please list any other diseases that run in your immediate family: ______________________________

System Review:
Check all applicable symptoms:

Constitutional: ☐ Recent weight change	☐ Fever	☐ Fatigue	☐ N/A
Eyes: ☐ Loss of Vision ☐ Left ☐ Right ☐ Both	☐ Pain ☐ Left ☐ Right ☐ Both	☐ Discharge/Tearing ☐ Left ☐ Right ☐ Both	☐ N/A
Ear, Nose, Mouth, Throat: ☐ Itchy ears ☐ Nosebleed ☐ Loss of sense of smell ☐ Mouth growth, ulcer ☐ Pain on swallowing ☐ Voice changes	☐ Facial weakness ☐ Sneezing ☐ Growth in nose ☐ Chewing difficulty ☐ Heartburn ☐ Breathing difficulty	☐ Nasal obstruction ☐ "Stuffy" nose ☐ Nasal bleeding ☐ Lump in neck ☐ Sore throat ☐ N/A	☐ Nasal discharge ☐ Snoring ☐ Drooling ☐ Dental problems/ Poorly fitting dentures ☐ Bleeding from throat
Cardiovascular: ☐ Chest pain ☐ Leg pain with rest	☐ Irregular Heart Beat ☐ N/A	☐ Swelling of legs	☐ Leg pain with walking
Respiratory: ☐ Wheezing ☐ Coughing up blood	☐ Cough ☐ N/A	☐ Shortness of breath	☐ Mucous
Gastrointestinal: ☐ Decrease in appetite ☐ Diarrhea/Constipation	☐ Nausea/Vomiting ☐ Indigestion	☐ Blood in stool ☐ Food intolerance	☐ Difficulty swallowing (food sticks) ☐ N/A
Musculoskeletal: ☐ Neck Pain	☐ Joint pain/Stiffness	☐ Arthritis Name Joint:	☐ N/A
Skin: ☐ Rash	☐ Jaundice	☐ Recent baldness	☐ N/A
Neurological: ☐ Headache ☐ Tremor	☐ Blackout ☐ N/A	☐ Seizures	☐ Paralysis
Psychiatric: ☐ Insomnia	☐ Depression	**On Medication:** ☐ Yes ☐ No	☐ N/A
Endocrine: ☐ Thyroid trouble ☐ N/A	☐ Heat or Cold Intolerance	☐ Excessive sweating	☐ Excessive thirst, hunger, urination
Genitourinary:			

☐ **Painful urination** ☐ **Difficulty passing urine**	☐ **Veneral disease** ☐ **Incontinence**	☐ **Blood in urine** ☐ **N/A**	☐ **Frequent urination at night**
Hematologic/Lymphatic: ☐ **Anemia**	☐ **Bleeding problems** ☐ **Easy bruising**	☐ **Blood disorder (eg. Sickle Cell)**	☐**N/A**

Do you have anything else to tell us about your particular problem that we have not asked you on this questionnaire?

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Physician Review with Patient:

____ **Physician Signature**

________________ **Date**