

Dizziness Evaluation

Patient: _____ Date: _____

I. When are you “dizzy” do you experience any of the following sensations? Please read the entire list first, circle ‘yes’ or ‘no’ to describe your feelings most accurately or fill in the blanks.

- YES NO 1. Lightheadedness or swimming sensation in the head.
- YES NO 2. Blacking out or loss of consciousness.
- YES NO 3. Tendency to fall: *To the right? Y or N To the Left? Y or N*
Forward? Y or N Backward? Y or N
- YES NO 4. Objects spinning or turning around you?
- YES NO 5. Sensation that you are turning or spinning inside, with outside objects remaining stationary.
- YES NO 6. Loss of balance when walking: *Veering to the right? Veering to the Left?*
- YES NO 7. Headache. Where? _____
- YES NO 8. Nausea.
- YES NO 9. Vomiting.
- YES NO 10. Pressure in the head. Where? _____
- YES NO 11. My dizziness is constant.
- YES NO 12. My dizziness is in attacks.
How often? _____
How long do they last? _____
When was the last attack? _____
13. When did your dizziness first occur? _____
- YES NO 14. Does change of position make you dizzy?
What positions? _____
- YES NO 15. Do you have trouble walking in the dark?
- YES NO 16. When you are dizzy must you support yourself when standing?
- YES NO 17. Do you know of any possible cause of your dizziness? *If so, what:*

- YES NO 18. Do you know of anything that will stop your dizziness or make it better? _____
Make your dizziness worse? _____
Cause an attack to begin? _____
- YES NO 19. Did you ever seriously injure your head?
Were you unconscious? Y or N
- YES NO 20. Do you have pain in the neck or shoulder?

II. Do you have any of the following symptoms? Please circle ‘yes’ or ‘no’ & which ear is involved.

- YES NO 1. Difficulty hearing. BOTH RIGHT LEFT
- YES NO 2. Noise in your ears. BOTH RIGHT LEFT
Does the noise change with dizziness? Y or N *If so, how?*

- YES NO 3. Fullness/stuffiness in your ears. BOTH RIGHT LEFT
- YES NO 4. Popping in the ears. BOTH RIGHT LEFT
- YES NO 5. Pain in your ears. BOTH RIGHT LEFT
- YES NO 6. Discharge from your ears. BOTH RIGHT LEFT