EAR, NOSE & THROAT & FACIAL PLASTIC SURGERY CENTER OF FREDERICKSBURG

DIZZINESS STUDY

NAME: _____ **DATE:** _____

PLEASE ANSWER ALL QUESTIONS

I. When you are "dizzy", do you experience any of the following sensations? PLEASE READ THE ENTIRE LIST FIRST. Then place and "X" in either the box marked **YES** or the box marked **NO** to describe your feelings most accurately.

YES	NO	
( )	( )	1. Lightheadedness
( )	( )	2. Swimming sensation in the head
( )	( )	3. Blacking out
( )	( )	4. Loss of consciousness
( )	( )	5. Tendency to fall: To the right?
( )	( )	To the left?
( )	( )	Forward?
( )	( )	Backward?
( )	( )	6. Objects spinning or turning around you?
( )	( )	7. Sensation that you are turning or spinning inside, with outside objects staying Stationary?
( )	( )	8. Loss of balance when walking: Veering to the right?
( )	( )	Veering to the left?
( )	( )	9. Headache?
( )	( )	10. Nausea or vomiting
( )	( )	11, Pressure in the head

II. PLEASE CHECK BOX FOR EITHER **YES** OR **NO** AND FILL IN THE SPACES

YES	NO	
( )	( )	1. My dizziness is constant
( )	( )	in attacks
		If in attacks, how often? _____
		How long do they last? _____
		2. When did dizziness first occur? _____
( )	( )	3. Can you tell when an attack is about to begin?
( )	( )	4. Are you completely free of dizziness between attacks?
( )	( )	5. Does change of position make you dizzy?
( )	( )	6. Do you have trouble walking in the dark?
( )	( )	7. When you are dizzy, can you stand up unsupported?
( )	( )	8. Do you know of any possible cause of your dizziness?
		What? _____

OVER

YES NO

( ) ( ) 9. Do you know of anything that stops your dizziness or makes it less severe?
What? _____

( ) ( ) 10. Were you exposed to any irritating fumes, paints, etc. at the onset of dizziness?

( ) ( ) 11. Do you have any allergies?

( ) ( ) 12. Did you ever injure your head?

( ) ( ) Were you unconscious?

( ) ( ) 13. Do you take any medications regularly?
What? _____

( ) ( ) 14. Do you use alcohol in any form?
What and how much? _____

III. DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? CHECK EITHER **YES** OR **NO** AND CIRCLE THE EAR INVOLVED

YES NO

( ) ( ) 1. Difficulty hearing? Both Ears Right Left

( ) ( ) 2. Noise in your ears? Both Ears Right Left
Describe the noise _____

( ) ( ) 3. Does noise in general change with Dizziness? If so, how? _____
_____

( ) ( ) 4. Fullness or stuffiness in your ears? Both Ears Right Left

( ) ( ) Does this change when you are dizzy?

( ) ( ) 5. Pain in your ears? Both Ears Right Left

( ) ( ) 6. Discharge/ drainage from your ears? Both Ears Right Left

IV. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS? CHECK EITHER **YES** OR **NO** AND CIRCLE **CONSTANT** OR **IN EPISODES**

YES NO

( )	( )	1. Double vision	Constant In episodes
( )	( )	2. Numbness of face or extremities	Constant In episodes
( )	( )	3. Blurred vision or blindness	Constant In episodes
( )	( )	4. Weakness in arms or legs	Constant In episodes
( )	( )	5. Clumsiness in arms or legs	Constant In episodes
( )	( )	6. Confusion or loss of consciousness	Constant In episodes
( )	( )	7. Difficulty with speech	Constant In episodes
( )	( )	8. Difficulty with swallowing	Constant In episodes