VERTIGO QUESTIONNAIRE – WESTERN CAROLINA EAR, NOSE, AND THROAT SPECIALISTS

PATIENT NAME: _____ DATE: _____

For questions that ask you to select an option, please circle the choice that best pertains to you.

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

Spinning in circles: yes no

Falling to one side: yes no

2. The following refer to your typical dizzy spells:

- How long does each dizzy spell last? _____
- How often do they occur? _____
- When do you recall having your first dizzy spell? _____
- Do the dizzy spells come in attacks? yes no
  - Are you free from dizziness between attacks? yes no
  - Do you feel that your attacks affect your hearing? yes no
  - Do attacks cause symptoms such as nausea? yes no
- Are you dizzy mainly when you sit up or stand up quickly? yes no
- Are you dizzier in certain positions? yes no
  - If so, which positions? _____
- Are you dizzy even when lying down? yes no
- Have you had a recent cold? yes no

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

- Do you blackout or faint when dizzy? yes no
- Have you had:
  - severe or recurring headaches? yes no
  - double or blurry vision? yes no
  - numbness in your face or extremities? yes no
  - weakness or clumsiness in arms or legs? yes no
  - difficulty swallowing? yes no
  - seizures, confusion, or memory loss? yes no
  - recent trauma to your head? yes no

4. The following refer to your hearing, please indicate which side has been affected:

- Difficulty hearing Right Left Both None
- Ringing sound Right Left Both None
- Ear fullness Right Left Both None
- Change in hearing Right Left Both None

Have you had any of the following?

- Ear pain Right Left Both None
- Previous ear surgery or infections Right Left Both None
- Family history of deafness Right Left Both None
- Drainage from ears Right Left Both None

5. The following refer to habits and lifestyle:

- Have you had any recent stress in your life recently? yes no
- Are you dizzy or unsteady constantly? yes no
- Is your dizziness related to:
  - Moments of stress? yes no
  - Menstrual period? yes no
- Do you feel lightheaded when you are dizzy? yes no
- Did you recently change eyeglasses? yes no

The answers to the above stated questions are true and accurate to the best of my knowledge.

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____