Pinnacle ENT ASSOCIATES LLC

VALLEY FORGE EAR, NOSE & THROAT ASSOCIATES DIVISION

# Dizziness/Imbalance Questionnaire

Patient Name _____ Date _____ /_____ /_____
First MI Last MM DD YYYY

1. Which of these best describes your dizziness? Choose only one:
   - ☐ A sensation of movement of yourself or the room: spinning, tilting, or wave-like movement
   - ☐ Light headedness or feeling that you are going to faint
   - ☐ Loss of balance, unsteadiness
   - ☐ Disorientation with the world, giddiness

2. When you are "dizzy" do you experience any of the following sensations? You may circle as many yes responses as necessary.

| | | |
|---|---|---|
| Yes | No | Light headedness or swimming sensation in the head |
| Yes | No | Blacking out or lack of consciousness |
| Yes | No | Tendency to fall |
| Yes | No | Objects spinning or turning around you |
| Yes | No | Sensation that you are turning or spinning inside |
| Yes | No | Loss of balance when standing or walking |
| Yes | No | Headache |
| Yes | No | Pressure in the head |
| Yes | No | Nausea or vomiting |

3. When did the dizziness first occur? _____

4. Is the dizziness CONSTANT or does it come in ATTACKS? _____

5. If the dizziness comes in attacks, how often do these attacks occur?

_____ times per day/week/month/year

6. If the dizziness comes in attacks, how often do these attacks last?

_____ seconds/minutes/hours/days

7. What factors provoke the dizziness or make the dizziness worse? _____

8. What makes the dizziness better? _____

9. Does your hearing change when the dizziness occurs? Yes No

   How? _____ Which ear? Right Left

10. Are there any other symptoms associated with the dizziness? Choose all that apply:
    - ☐ Blurred vision
    - ☐ Double vision
    - ☐ Numbness or tingling in the arms or legs
    - ☐ Weakness in the arms or legs
    - ☐ Difficulty speaking
    - ☐ Difficulty swallowing

11. Are you completely free of dizziness between attacks? Yes No

12. Does blowing your nose, coughing, or lifting heavy objects make you dizzy? Yes No

13. Do loud sounds or your own raised voice make you dizzy? Yes No

14. Have you ever been diagnosed with a head or neck injury? Yes No

If yes, please explain:

_____

_____

_____

15. Do you have any history of a neurological disease such as migraine, multiple sclerosis, or stroke? Yes No

If yes, please explain:

_____

_____

16. Do you have any of the following symptoms? Please circle Yes or No and circle which ear is involved:

Yes No Difficulty hearing? Right Left

Yes No Noise in your ears (tinnitus)? Right Left

Yes No Does tinnitus change during the dizziness?

If yes, then how? _____

Yes No Fullness or stuffiness in your ears? Right Left