Dizziness History

NAME _____ DATE _____

REFERRING PHYSICIAN _____ D.O.B. _____

PLEASE ANSWER ALL QUESTIONS

When you are "dizzy" do you experience any of the following sensations? Place an "X" in either the first space for YES or the second space for NO to describe your experience accurately.

YES	NO	
_____	_____	1. Lightheadedness
_____	_____	2. Swimming sensation in the head.
_____	_____	3. Blacking out.
_____	_____	4. Loss of consciousness
		5. Tendency to fall towards the: _____Right _____ Left _____Forwards _____Backwards
_____	_____	6. Objects appear to be spinning around you.
_____	_____	7. Sensation that you are spinning around.
_____	_____	8. Loss of balance when walking: _____Veering to the right _____ Veering to the left
_____	_____	9. Headache
_____	_____	10. Nausea and/or vomiting.

*Please check space for **YES** or **NO** and fill in the blank spaces.*

_____	_____	1. My dizziness is always present.
_____	_____	2. My dizziness (attacks) come and go. How often?_____ How long do they last? _____ When did dizziness first occur? _____
_____	_____	3. Can you tell when an attack is about to start?_____
_____	_____	4. Is the dizziness completely gone between attacks?
_____	_____	5. Does change in position make you dizzy?
_____	_____	6. When you are dizzy, can you stand up unsupported?
_____	_____	7. Do you know any possible cause for your dizziness? What?_____
_____	_____	8. Do you know of anything that will: Stop your dizziness or make it better? _____

Make your dizziness worse? _____

_____ _____ 9. Do you have allergies? _____
_____ _____ 10. Do you take any medications regularly?

Do you have any of the following symptoms?
*Check either **YES** or **NO** and **CIRCLE** the ear that is involved.*

YES	NO		
_____	_____	1. Difficulty in hearing?	___Both ears? ___Right?___Left?
_____	_____	2. Noise in your ears?	___Both ears? ___Right?___Left?
		Describe the noise:	
		_____	
		Does the noise change with the dizziness? If so, how?	
		_____	
_____	_____	3. Fullness or stuffiness in your ears?	___Both ears? ___Right?___Left?
_____	_____	4. Pain in your ears?	___Both ears? ___Right?___Left?
_____	_____	5. Discharge from your ears?	___Both ears? ___Right?___Left?

Have you experiences any of the following symptoms?
*Please check either **YES** or **NO** and **MARK** either **CONSTANT** or **AT TIMES**.*

YES	NO			
_____	_____	1. Doubled vision	_____Constant	_____At Times
_____	_____	2. Blurred vision	_____Constant	_____At Times
_____	_____	3. Numbness of your face	_____Constant	_____At Times
_____	_____	4. Weakness in arms or legs	_____Constant	_____At Times
_____	_____	5. Difficulty with speech	_____Constant	_____At Times
_____	_____	6. Difficulty with swallowing	_____Constant	_____At Times
_____	_____	7. Confusion	_____Constant	_____At Times

Please provide any other information that is relevant to your attacks or dizziness:

_____
_____
_____
_____
_____
_____

Signature of person filling out form _____

PLEASE BRING THE *COMPLETED* FORM TO YOUR VNG APPOINTMENT.