Elizabeth Welch, Au.D.
Bridget Lee, Au.D.
Rachel Tuberville, Au.D.
Erica Thayer, Au.D.

Today's Date ______________________________

Name ______________________________ Sex M F Date of Birth ______________________ Age ________

1. Please describe in your own words the sensation you feel without using the word "dizzy". ______________________

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2. Do you ever notice any of the following sensations:

• Spinning in circles	Yes	No
• Falling to one side	Yes	No
• World spinning around you	Yes	No

3. Please indicate the following:

• Do the dizzy spells come in attacks?	Yes	No
• How often? ______________________		
• How long does each attack last? ____________		
• Date of first episode? __________________		
• Are you free from dizziness between spells?	Yes	No
• Are you dizzier in certain positions?	Yes	No
Please list ______________________		
• Are you nauseated during an episode?	Yes	No
• Do you get dizzy when you lie down?	Yes	No
• Do you get dizzy when you roll over?	Yes	No
If so, which direction? RIGHT LEFT BOTH		
• Have you had a recent cold preceding this episode?	Yes	No
• Fullness or pressure in your ears?	Yes	No
If so, which ear? RIGHT LEFT BOTH		
• Do you have trouble walking in the dark?	Yes	No
• Are you better if you sit or lie still?	Yes	No
• Do you black out or faint when you are dizzy?	Yes	No
• Are you dizzy or unsteady constantly?	Yes	No
* Any double or blurry vision?	Yes	No
• Numbness in your face or extremities?	Yes	No
• Weakness or clumsiness in arms or legs?	Yes	No
• Slurred or difficult speech?	Yes	No
• Difficulty swallowing?	Yes	No
• Tingling around your mouth?	Yes	No
• Spots before your eyes?	Yes	No
• Jerking of your arms or legs?	Yes	No
• Head injury with loss of consciousness?	Yes	No
• Confusion or memory loss?	Yes	No

4. The following has to do with your hearing

• Does your hearing change with episodes?	Yes	No
If so, which ear? RIGHT LEFT BOTH		
• Do your ears ring with episodes? Yes No		
If so, which ear? RIGHT LEFT BOTH		
• Previous ear infections?	Yes	No
If so, which ear? RIGHT LEFT BOTH		
• Previous ear surgery?	Yes	No
If so, which ear? RIGHT LEFT BOTH		
Surgical procedure and date? ______________________________		

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- Family history of hearing loss? Yes No
- Pain in ears? Yes No
  - If so, which ear? RIGHT LEFT BOTH

5. Is your dizziness related to any of the following?
   - Stress Yes No
   - Menstrual period Yes No
   - Overwork or exertion Yes No
   - Headaches Yes No
   - Eye strain Yes No
6. Do you feel lightheaded or a swimming sensation? Yes No
7. Did you recently change eyeglasses? Yes No
8. Do you drink tea? Yes No How much? ____________________
9. Do you drink coffee? Yes No How much? ____________________
10. Do you drink soft drinks? Yes No How much? ____________________
11. Do you drink alcohol? Yes No How much? ____________________
12. Do you smoke? Yes No How much? ____________________

Please list your current medical problems and length of illness: ____________________

____

Please list your surgeries performed and approximate dates: ____________________

____

Please list medications you are currently taking: ____________________

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13. Do you have any of the following:

Diabetes	Yes	No
Low blood sugar	Yes	No
High blood pressure	Yes	No
Low blood pressure	Yes	No
Thyroid disease	Yes	No
Heart disease	Yes	No
Asthma	Yes	No

14. Are you allergic to anything? Yes No
    Please list: ____________________
15. What exams have previously been completed and approximate dates: (including hearing tests, xray, scans): ____________________

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16. Any other information you feel is pertinent to your symptoms of “dizziness”? ____________________

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17. Have you fallen 2x in the past 12 months OR 1x with an injury? YES NO N/A for medical reasons

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