

**BURLINGTON EAR, NOSE & THROAT CLINIC, P.C.**  
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Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Date \_\_\_\_\_

The following questions refer to your feeling of dizziness. Please answer them as “yes” or “no” and fill in all the blanks.

1. Please describe, in your own words, the sensation you feel without using the word “dizzy.” \_\_\_\_\_

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

- |     |                            |    |
|-----|----------------------------|----|
| Yes | Spinning in circles?       | No |
| Yes | Falling to one side?       | No |
| Yes | World spinning around you? | No |

3. The following refer to a typical dizzy spell:

- |     |                                      |    |
|-----|--------------------------------------|----|
| Yes | Do the dizzy spells come in attacks? | No |
|-----|--------------------------------------|----|

How often? \_\_\_\_\_

How long? \_\_\_\_\_

Date of first spell? \_\_\_\_\_

- |     |   |    |
|-----|---|----|
| Yes | Are you free from dizziness between attacks?            | No |
| Yes | Does your hearing change with an attack?                | No |
| Yes | Are you dizzy in certain positions?                     | No |
|     | Which position? _____                                   |    |
| Yes | Are you nauseated during an attack?                     | No |
| Yes | Are you dizzy even when lying down?                     | No |
| Yes | Had a recent cold or flu preceding recent dizzy spells? | No |
| Yes | Fullness or pressure or ringing in your ears?           | No |
| Yes | Pain or discharge in your ear of recent onset?          | No |
| Yes | Trouble walking in the dark?                            | No |
| Yes | Are you better if you sit or lie perfectly still?       | No |

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

- |     |   |    |
|-----|---|----|
| Yes | Do you black out or faint when you are dizzy? | No |
| Yes | Are you dizzy or unsteady constantly?         | No |
| Yes | Do you have severe or recurrent headaches?    | No |
| Yes | Any double or blurry vision?                  | No |
| Yes | Numbness in your face or extremities?         | No |
| Yes | Weakness or clumsiness in your arms, legs?    | No |
| Yes | Slurred or difficult speech?                  | No |
| Yes | Difficulty swallowing?                        | No |
| Yes | Tingling around your mouth?                   | No |
| Yes | Spots before your eyes?                       | No |
| Yes | Jerking of arms and legs?                     | No |
| Yes | Head injury with loss of consciousness?       | No |
| Yes | Confusion or memory loss?                     | No |

5. The following refer to your hearing:

- |     |   |    |
|-----|---|----|
| Yes | Difficulty hearing in one ear? Left _____ Right _____ | No |
| Yes | Ringing in one ear? Left _____ Right _____            | No |

- |     |  |    |
|-----|--|----|
| Yes | Fullness in one ear? Left ____ Right ____  | No |
| Yes | Change in hearing when dizzy?<br>How? _____  | No |
| Yes | Exposure to loud noises?   | No |
| Yes | Previous ear infections?   | No |
| Yes | Previous ear surgery?<br>What? _____ When? _____   | No |
| Yes | Family history of deafness?  | No |
| Yes | Pain in ears? Left ____ Right ____   | No |
| Yes | Discharge from ears? Left ____ Right ____  | No |
| Yes | Hearing changing? Left ____ Right ____   | No |
| Yes | Better? Left ____ Right ____   | No |
| Yes | Worse? Left ____ Right ____  | No |
| 6.  | The following refer to habits and lifestyle:   |    |
| Yes | Is there added stress in your life recently?   | No |
| 7.  | Is your dizziness related to any of the following?   |    |
| Yes | Moments of stress?   | No |
| Yes | Menstrual period?  | No |
| Yes | Overwork or exertion?  | No |
| Yes | Do you feel lightheaded or have a swimming sensation when dizzy?   | No |
| Yes | Do you find yourself breathing faster or deeper when excited or dizzy?   | No |
| Yes | Did you recently change eyeglasses?  | No |
| Yes | Do you drink coffee? How much? _____   | No |
| Yes | Do you drink tea? How much? _____  | No |
| Yes | Do you drink soft drinks? How much? _____  | No |
| Yes | Do you drink alcohol? How much? _____  | No |
| Yes | Do you smoke? What? _____ How much? _____  | No |
| 8.  | What studies have been done previously ( e.g., hearing, radiographs, head scans)?<br>_____<br>_____  |    |
| 9.  | Do you have anything else to add about your particular problem that has not been<br>addressed on this questionnaire? _____<br>_____<br>_____ |    |