Lisa B. David, M.D.   Brytton B. Eldredge, M.D.

EVALUATION FOR DIZZINESS

Patient: ____ DOB: _________________ DATE: _____________

I. When you are "dizzy", do you experience any of the following sensations? Please read the entire list first, then mark an "X" on the line (yes or no) that describes your feelings most accurately.

YES	NO	
____	____	1. Lightheadedness
____	____	2. Swimming sensation in the head
____	____	3. Blacking out
____	____	4. Loss of consciousness
____	____	5. Tendency to fall: To the right?
____	____	To the left?
____	____	Forward?
____	____	Backward"
____	____	6. Objects spinning or turning around you
____	____	7. Sensation that you are spinning or turning in side with outside objects remaining stationary
____	____	8. Loss of balance when walking: Veering to the right?
		Veering to the left?
____	____	9. Headache
____	____	10. Nausea or vomiting
____	____	11. Pressure in the head

II. Please mark an "X" on the line for either YES or NO and fill in the blank spaces.

YES	NO	
_____	_____	1. My dizziness is: constant?
____	____	in attacks?
		2. When did dizziness first occur? ____
		3. If in attacks:
		How often? ____
		How long do they last? ____
____	____	4. Are you completely free of dizziness between attacks?
____	____	5. Does dizziness occur only in certain places?
____	____	6. Do you have trouble walking in the dark?
____	____	7. When dizzy, must you support yourself when standing?
____	____	8. Do you know of any possible cause of your dizziness?
		If YES, what? ____
		9. Do you know of anything that will:
____	____	stop your dizziness or make it better? ______________________________
____	____	Make your dizziness worse? ______________________________
____	____	Precipitate an attack? ______________________________
____	____	10. Were you exposed to any irritating fumes, paints, etc. at the onset of dizziness?
____	____	11. Do you have any allergies?
____	____	12. Did you ever injure your head?
____	____	If YES, were you unconscious?
____	____	13. Do you take any medications regularly?
		If YES, what? ____

CONTINUED ON BACK

Patient: ____DOB: ________________ Date: ____________

YES	NO	
____	____	14. Do you use tobacco in any form?
		If YES, how much? ____
____	____	15. Do you drink alcohol?
____	____	16. Have you ever had ear surgery?

III. Do you have any of the following symptoms? Mark an "X" on the appropriate line and circle the ear involved.

YES	NO				
____	____	1. Difficulty hearing?	Both ears	Right	Left
		When did this first start? ____			
____	____	Is it getting worse?			
____	____	2. Noise in your ears?			
		Describe noise ____			
____	____	Does the noise change with dizziness?			
		If YES, how? ____			
____	____	Does anything stop the noise or make it better?			
____	____	3. Fullness/stuffiness in your ears?	Both ears	Right	Left
____	____	Does this change when you are dizzy?			
____	____	4. Pain in your ears?	Both ears	Right	Left
____	____	5. Discharge from your ears?	Both ears	Right	Left

IV: Have you ever experienced any of the following symptoms? Mark an "X" on the appropriate lines and circle if CONSTANT or EPISODES?

YES	NO			
____	____	1. Double Vision	CONSTANT	EPISODES
____	____	2. Numbness of face or extremities	CONSTANT	EPISODES
____	____	3. Blurred vision or blindness	CONSTANT	EPISODES
____	____	4. Weakness in arms or legs	CONSTANT	EPISODES
____	____	5. Clumsiness in arms or legs	CONSTANT	EPISODES
____	____	6. Confusion or loss of consciousness	CONSTANT	EPISODES
____	____	7. Difficulty with speech	CONSTANT	EPISODES
____	____	8. Difficulty Swallowing	CONSTANT	EPISODES
____	____	9. Tingling around mouth	CONSTANT	EPISODES
____	____	10. Spots before eyes	CONSTANT	EPISODES

V. Please mark an "X" for either YES or NO.

YES	NO	
____	____	1. Do you get dizzy after exertion or overwork?
____	____	2. Did you get new glasses recently?
____	____	3. Do you tend to get upset easily?
____	____	4. Do you get dizzy when you have not eaten for a long time?
____	____	5. Is your dizziness connected with your menstrual period?
____	____	6. Have you ever had a neck injury?

REVIEWED: ________________________ ___________________________

Lisa B. David, M.D. Brytton B. Eldredge, M.D.