HarmonyHearing & Audiology

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DIZZINESS QUESTIONNAIRE

Name____ Date ____________________________

Which of the following best describes your dizziness?

☐ Spinning Sensation ☐ General Disequilibrium/Imbalance ☐ Light-Headedness ☐ Other ____________________

Do you have a history of **headaches/migraines**? ☐ Yes ☐ No

Does your dizziness **come in spells**? ☐ Yes ☐ No If so, how long do they last? ___________________________

Is your dizziness evoked by any of the following?

☐ Loud Sounds ☐ Change in pressure

Is your dizziness ever accompanied by any of the following?

☐ Nausea ☐ Vomiting ☐ Vision Problems ☐ Numbness ☐ Weakness of Breath ☐ Loss of Consciousness

When was the **first time** you experienced the dizziness? ______________ When was the **last time**? ________________

Is your dizziness affected by changes in **body position**? ☐ Yes ☐ No

Have you experienced any **hearing difficulties**? ☐ Yes ☐ No If so, how long? ___________________________

Have you recently experienced any of the following?

☐ Sudden Change in Hearing ☐ Ear Pain ☐ Ear Pressure/Fullness ☐ Ear Drainage ☐ Other ________________

Do you hear noises, ringing, or **sounds in your ears** lasting longer than 2 minutes at a time? ☐ Yes ☐ No

Have you ever experienced any of the following?

☐ Allergies ☐ Head Injury ☐ Neurological Problems ☐ Surgery of the head or ears
☐ Cancer ☐ Heart Problems ☐ Sinus Problems ☐ Carotid Artery Problems
☐ Diabetes ☐ High Blood Pressure ☐ Stroke/TIA ☐ Neck/Back Problems

Are you currently taking any **prescription medications**? ☐ Yes ☐ No

Have you consumed any medication or alcohol during the **past 24 hours**? ☐ Yes ☐ No

Additional Comments ____