Harmony Hearing & 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 fallen within the **past 12 months**? • Yes • No

Have you ever experienced any of the following?

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