Medical Record #: _____

Hackensack Meridian *Health*
Joseph M. Sanzari Children's Hospital

Audiology Department
(551) 996-5327

DIZZINESS HISTORY QUESTIONNAIRE

PATIENT INFORMATION

Patient's Name: _____

Date of Birth: _____ Date(s) of Evaluation: _____

_____ _____

Signature of Patient/Parent/Guardian *Relationship to Patient*

PREFERRED PROVIDER INFORMATION

Check box if you would like us to send results to your provider

Primary Care Physician/Pediatrician: Address: City/State/Zip: Phone Number: Fax Number:	☐
ENT/Otolaryngologist: Address: City/State/Zip: Phone Number: Fax Number:	☐
Hearing Aid Dispenser: Address: City/State/Zip: Phone Number: Fax Number:	☐
Other: Address: City/State/Zip: Phone Number: Fax Number:	☐

PATIENT INFORMATION

First, Middle, Last Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Phone Number: _____ Email: _____

Primary Language: _____

Primary concern for this appointment: _____

Who referred you for this appointment? _____

REFERRING PHYSICIAN INFORMATION

Physician Name: _____

Phone Number: _____ Fax Number: _____

Address: _____

City/State: _____ Zip: _____

VESTIBULAR HISTORY

1. When was the first time you experienced dizziness? What were the circumstances?
   Was the onset of your symptoms: □ Sudden □ Gradual □ Overnight
   _____

2. When was the last time you experienced dizziness? What were the circumstances?
   _____

3. Currently my dizziness…(check ONE)
   - □ Is constant
   - □ Is always there, but changes in intensity
   - □ Comes and goes. If so…
     How long does it last? □ Seconds □ Minutes □ Hours
     How often does it occur? _____ times per _____ (day/week/month/year)

4. My dizziness mostly consists of…(check ALL that apply)
   - □ Spells of spinning with nausea
   - □ Off-balance sensation/unsteadiness
   - □ A light-headed or near faint sensation
   - □ Other. Please explain: _____

5. Between episodes I feel…(check ONE)
   - □ Dizzy or off balance all the time
   - □ Normal
   - □ Other. Please explain: _____

6. My episodes occur…(check ALL that apply)
   - □ Spontaneously. Nothing I do seems to bring them on or turn them off
   - □ Only when standing or walking
   - □ In relation to any head motion
   - □ In relation to only certain head positions

7. Do you have any warning signs that an episode is about to occur? YES NO
   If so, please explain: _____

8. When I roll over in bed…(check ONE)
   - □ Nothing unusual happens
   - □ The room seems to spin sometimes
   - □ The room spins every time

9. Is there anything that you can do to make your dizziness go away? (Sit/lie down/close eyes)
   Please explain: _____

10. Is there anything that makes your dizziness worse?
    Please explain: _____

11. Check ALL that apply:

I have hearing difficulty	□ Right	□ Left	□ Both
I have ringing in my ears	□ Right	□ Left	□ Both
I have fullness (pressure)	□ Right	□ Left	□ Both
I have had ear surgery	□ Right	□ Left	□ Both

12. When was your last hearing evaluation? _____
    What were the results? _____

13. Please circle Yes or No:

Did you have a cold/flu/virus type symptoms shortly before the onset of your dizziness?	Yes	No
Were you exposed to any irritating fumes, paints, etc. at the onset of your dizziness?	Yes	No
Do you get dizzy if you have not eaten?	Yes	No
Did you cough, lift, sneeze, fly in a plane, swim under water, or suffer head trauma shortly before the onset of your dizziness?	Yes	No
Did you get new glasses recently?	Yes	No
I consider myself to be anxious/tense.	Yes	No
I am under a great deal of stress.	Yes	No
I need to support myself to stand/walk.	Yes	No
I have fallen as a result of my current problem.	Yes	No

14. When you are walking, do you: □ Lean left? □ Lean right? □ Remain in a straight path?
    Please explain: _____

MEDICAL HISTORY

15. In the past year I have had…(check ALL that apply)

□ Loss of consciousness	□ Occasional loss of vision	□ Double vision
□ Heart palpitations	□ Severe headache/migraine	□ Seizures or convulsions
□ Slurring of speech	□ Weakness in hand/arm/leg	□ Tendency to fall
□ Difficulty swallowing	□ Tingling around the mouth	
□ Spots before the eyes	□ Loss of balance when walking	

16. I have or have had…(check ALL that apply)

□ Diabetes	□ Stroke	□ Multiple Sclerosis
□ High blood pressure	□ Migraine headaches	□ Parkinson's Disease
□ Arthritis	□ Neck/back injury	□ Macular Degeneration
□ Irregular heartbeat	□ Seasonal allergies	

17. Please check below for any medications you have tried or are currently taking for your dizziness:

	In past	Now	Helps
Antivert (meclizine)	□	□	□
Valium (diazepam)	□	□	□
Dyazide "water pills"	□	□	□

18. Please list any medications you are currently taking:_____

_____

19. Please list any surgeries you have had: _____

_____