

OSENTA  
**Ottawa Shores E.N.T. Associates, P.C.**  
**PATIENT DIZZINESS HISTORY QUESTIONNAIRE**

In order for us to provide you the best care, it is important for you to fill out this form as completely as possible. Try to fill this out the day before or morning of your appointment so that all information is as accurate as possible. Remember we will need this completed before you arrive for your appointment. **Please fill out every item.** It is important for your doctor to know that you have carefully reviewed every area of this form. This information will be computerized; you are welcome to a copy if you wish.

Full Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Referring Physician \_\_\_\_\_ Primary Care Physician \_\_\_\_\_  
(Name of person completing form \_\_\_\_\_ and Relationship to Patient \_\_\_\_\_)

1. Quality, how would you best describe your dizzy episodes (check all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> sensation is primarily light headedness                         | <input type="checkbox"/> clumsy sensation                           |
| <input type="checkbox"/> sensation is primarily unsteadiness                             | <input type="checkbox"/> feeling of impending loss of consciousness |
| <input type="checkbox"/> sensation of spinning motion                                    | <input type="checkbox"/> floating sensation                         |
| <input type="checkbox"/> drifting or rocking sensation as if on a boat                   | <input type="checkbox"/> difficult controlling the body             |
| <input type="checkbox"/> buzzy, strange sensation in the head but no feeling of motion   | <input type="checkbox"/> other type of sensation _____              |
| <input type="checkbox"/> spinning feeling inside the head, no actual sensation of motion |   |

2. Severity, how would you rate the dizziness in comparison to the effect on your daily activities:

- mild, has no effect on daily activities  
 moderate, interfering with daily activities to some degree  
 severe, must constantly make adjustment to daily activities  
 very severe, cannot engage in normal activities  
 extremely severe, have been disabled for one year or more

Change in severity since dizziness first began:

- no change                       more severe  
 less severe                       other \_\_\_\_\_

3. Timing, how long ago did the most recent episode of dizziness start:

- |  |   |
|--|---|
| <input type="checkbox"/> minutes _____ | <input type="checkbox"/> months _____     |
| <input type="checkbox"/> hours _____   | <input type="checkbox"/> years _____      |
| <input type="checkbox"/> days _____    | <input type="checkbox"/> exact date _____ |
| <input type="checkbox"/> weeks _____   | <input type="checkbox"/> cannot remember  |

How long did the episode last:

- |  |   |
|--|---|
| <input type="checkbox"/> seconds _____ | <input type="checkbox"/> weeks _____      |
| <input type="checkbox"/> minutes _____ | <input type="checkbox"/> months _____     |
| <input type="checkbox"/> hours _____   | <input type="checkbox"/> years _____      |
| <input type="checkbox"/> days _____    | <input type="checkbox"/> exact time _____ |

What was the pattern of development:

- |  |   |
|--|---|
| <input type="checkbox"/> almost instantly  | <input type="checkbox"/> unknown                          |
| <input type="checkbox"/> very rapidly (seconds or minutes)                         | <input type="checkbox"/> irrelevant--was problem at birth |
| <input type="checkbox"/> steadily (over time from hours to years)                  | <input type="checkbox"/> other _____                      |
| <input type="checkbox"/> in start and stop fashion (over time from hours to years) |   |

Were there definite times when the dizziness was worse (time of day, day of week, season, etc.):  Yes  No

If yes please check one of the following:

- |   |  |
|---|--|
| <input type="checkbox"/> time of day when worse _____   | <input type="checkbox"/> time of week when worse _____ |
| <input type="checkbox"/> season of year when worse _____  | <input type="checkbox"/> other times _____             |
| <input type="checkbox"/> there were variations in severity, but not relevant to any specific time |  |

Is the dizziness a recurrent problem:  Yes  No (move on to number 4)

Date of first occurrence:

- |   |  |
|---|--|
| <input type="checkbox"/> specific date and time _____ | <input type="checkbox"/> years _____     |
| <input type="checkbox"/> days _____                   | <input type="checkbox"/> since childhood |
| <input type="checkbox"/> weeks _____                  | <input type="checkbox"/> since birth     |
| <input type="checkbox"/> months _____                 | <input type="checkbox"/> unknown         |

Duration of typical dizzy episodes:

- |  |   |
|--|---|
| <input type="checkbox"/> seconds _____ | <input type="checkbox"/> months _____     |
| <input type="checkbox"/> minutes _____ | <input type="checkbox"/> years _____      |
| <input type="checkbox"/> hours _____   | <input type="checkbox"/> exact time _____ |
| <input type="checkbox"/> weeks _____   | <input type="checkbox"/> unknown          |

Changes in frequency or duration since dizziness first began:

- |  |  |
|--|--|
| <input type="checkbox"/> none                      | <input type="checkbox"/> lasting longer                    |
| <input type="checkbox"/> occurring more frequently | <input type="checkbox"/> occurring less frequently         |
| <input type="checkbox"/> not lasting as long       | <input type="checkbox"/> other description of change _____ |

4. Setting in which dizziness first occurred:

- |  |  |
|--|--|
| <input type="checkbox"/> getting out of bed                | <input type="checkbox"/> after head injury             |
| <input type="checkbox"/> after exposure to very loud noise | <input type="checkbox"/> after CVA (stroke) date _____ |
| <input type="checkbox"/> after upper respiratory infection | <input type="checkbox"/> other _____                   |
| <input type="checkbox"/> none                              |  |

5. Aggravating factors (check all that apply):

- |   |   |
|---|---|
| <input type="checkbox"/> rapid change in position           | <input type="checkbox"/> rotating the head              |
| <input type="checkbox"/> rapid eye motion                   | <input type="checkbox"/> walking                        |
| <input type="checkbox"/> exercise                           | <input type="checkbox"/> sneezing or coughing           |
| <input type="checkbox"/> exposure to loud noise             | <input type="checkbox"/> looking up, or up and backward |
| <input type="checkbox"/> using the arms quickly or forcibly | <input type="checkbox"/> other _____                    |
| <input type="checkbox"/> none                               |   |

6. Relieving factors (check all that apply):

- laying down                       other \_\_\_\_\_  
 holding very still                 none

7. Other associated problems (check all that apply):

- sensation of ear pressure or fullness    which ear:     left    right    both  
 hearing loss                                    which ear:     left    right    both  
 ear pain    which ear:     left    right    both  
 ear drainage                                    which ear:     left    right    both    color \_\_\_\_\_  
 tinnitus (ringing or noises in the ear)    which ear:     left    right    both  
 head or facial trauma    describe \_\_\_\_\_  
 severe headache  
 visual changes  
 mental status change  
 loss of consciousness  
 chest pain  
 difficulty breathing  
 nausea or vomiting  
 numbness, tingling or weakness of body limbs  
 allergies  
 other \_\_\_\_\_  
 none

8. Previous tests or evaluations (check all that apply):

- hearing testing, when and where was this performed \_\_\_\_\_  
 balance testing, when and where was this performed \_\_\_\_\_  
 bloodwork, when and where was this performed \_\_\_\_\_  
 scans or x-rays, when and where was this performed \_\_\_\_\_  
 other \_\_\_\_\_  
 none

9. Previous treatment (check all that apply)

- home remedies  
 over-the-counter medications used for the symptom \_\_\_\_\_  
 prescription medication \_\_\_\_\_  
 ear surgery for dizziness \_\_\_\_\_  
 Epley exercises; treatment effectiveness was \_\_\_\_\_  
 other \_\_\_\_\_  
 none

**10. Previous medical opinion (list provider name, specialty, date of most recent visit and providers opinions regarding the dizziness):**

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**11. Patient's statement regarding effect on life:**

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