ROCKY MOUNTAIN EAR, NOSE & THROAT
200 W. COUNTY LINE ROAD SUITE #330
HIGHLANDS RANCH, CO 80129
303-795-5587

Patient Name: _____ **Date:** _____

Patient Vertigo Questionnaire

(Please answer each question by checking the box which best describes your experience accurately.)

Section I - When you experience being 'dizzy' do you have any of the following sensations?

1. Light headedness or swimming sensation in your head.		Yes ☐ No ☐
2. Blacking out or loss of consciousness.		Yes ☐ No ☐
3. Tendency to fall:	To the right.	Yes ☐ No ☐
	To the left.	Yes ☐ No ☐
	Forward.	Yes ☐ No ☐
	Backward.	Yes ☐ No ☐
4. Objects spinning or turning around you.		Yes ☐ No ☐
5. Sensation that you are turning or spinning inside, with outside objects remaining stationary.		Yes ☐ No ☐
6. Loss of balance when walking:	To the right.	Yes ☐ No ☐
	To the left.	Yes ☐ No ☐
7. Headache.		Yes ☐ No ☐
8. Nausea or vomiting.		Yes ☐ No ☐
9. Pressure in the head.		Yes ☐ No ☐

(Please answer each question by checking the box which best describes your experience accurately or filling in blank spaces when asked.)

Section II - Describing your dizziness.

1. When did your dizziness first occur?		_____
2. My dizziness is:	Constant.	Yes ☐ No ☐
	Intermittent attacks.	Yes ☐ No ☐
If you answered Intermittent attacks:	How often.	_____
	How long.	_____
	Date of last attack.	_____
	Warning that attack will start.	Yes ☐ No ☐
	Describe:	_____
	Specific time of day/night	Night ☐ Day ☐ Both ☐
	Free of dizziness between attacks.	Yes ☐ No ☐

(Please check the appropriate box for each symptom and circle which ear is involved.)

Section III - Symptom descriptions.

1. Difficulty in hearing? Yes ☐ No ☐
   Both ears
   Right ear only
   Left ear only

2. Noise in your ear(s)? Yes ☐ No ☐
   Both ears
   Right ear only
   Left ear only
   Noise description:
   _____
   _____

3. Fullness or stuffiness in your ears? Yes ☐ No ☐
   Both ears
   Right ear only
   Left ear only

4. Pain in your ears? Yes ☐ No ☐
   Both ears
   Right ear only
   Left ear only

5. Discharge from ears? Yes ☐ No ☐
   Both ears
   Right ear only
   Left ear only

(Please check the appropriate box for each symptom and circle if Constant or Episodes.)

Section IV - Symptom descriptions.

1. Double vision, blurred vision or blindness: Yes ☐ No ☐
   Constant
   Episodes

2. Numbness of face or extremities: Yes ☐ No ☐
   Constant
   Episodes

3. Weakness in arms and legs? Yes ☐ No ☐
   Constant
   Episodes

4. Clumsiness in arms or legs? Yes ☐ No ☐
   Constant
   Episodes

Section II - (Continued)

3. Does a change of position make you dizzy? Yes ☐ No ☐

4. Do you have trouble walking in the dark? Yes ☐ No ☐

5. Must you support yourself when dizzy? Yes ☐ No ☐

6. Do you know of any possible causes for your dizziness? Yes ☐ No ☐
   Describe if Yes:
   _____
   _____
   _____

7. What will:
   Stop your dizziness. _____
   Make it better. _____
   Make it worse. _____

8. Will any of the following start an attack.
   Fatigue. Yes ☐ No ☐
   Exertion. Yes ☐ No ☐
   Hunger. Yes ☐ No ☐
   Menstrual period. Yes ☐ No ☐
   Stress. Yes ☐ No ☐
   Emotional upset. Yes ☐ No ☐

9. Were you exposed to any irritation fumes, paints, etc., at the the onset of dizziness? Yes ☐ No ☐

10. Do you have any allergies? Yes ☐ No ☐
    If Yes, please list:
    _____
    _____
    _____
    _____

11. Have you ever sustained an injury to your head? Yes ☐ No ☐
    If Yes, were you unconscious? Yes ☐ No ☐

12. Do you take medications regularly? Yes ☐ No ☐
    If Yes, please list:
    _____
    _____
    _____
    _____
    _____
    _____

13. Do you use tobacco, in any form? Yes ☐ No ☐
    If Yes, how much:
    _____
    _____
    _____

Section IV - (Continued)

5. Confusion or loss of consciousness?	Yes ☐	No ☐ Constant Episodes
6. Difficulty with speech?	Yes ☐	No ☐ Constant Episodes
7. Difficulty with swallowing?	Yes ☐	No ☐ Constant Episodes
8. Pain in the neck or shoulder?	Yes ☐	No ☐ Constant Episodes

Thank you for your time and patience in completing this questionnaire.