

Dizziness, Vertigo and Imbalance Questionnaire

Name _____ Date _____

Please Briefly Describe Your Symptoms: _____

Please Circle all that apply to you:

| | |
|----------------------------------|--|
| Dizziness | Symptoms occur with Standing |
| Vertigo (spinning) | Symptoms Associated with Medication |
| Lightheaded | Symptoms associate with Position Changes |
| Nausea or Vomiting | Symptoms Rolling over in Bed |
| Onset Sudden or Gradual | Symptoms Looking Up or Bending Over |
| Headaches or history of Headache | Symptoms Brought on by Noise |
| Blurred or Double Vision | Symptoms Brought on by Exercise |
| Visual Loss | Symptoms Brought on by Straining |
| Hearing Aid | Symptoms Brought on by Stress |
| Weakness or Numbness | Symptoms Occur with Head Movement |
| Loss of balance | Symptoms Occur Walking in the Dark |
| Falls (if so, how many? ____) | Sleep with Head Elevated |
| Fear of Falling | Hearing Loss |
| Faint or Loss of Consciousness | Ring in Ears |
| Symptoms Always Present | Fullness or Pressure in Ears |
| Symptoms Episodic | Recent Travel |
| How long? _____ | Head Injury |
| How frequent? _____ | Underwater Diving |

Prior Testing (Please Circle all that Apply):

| | | | | |
|-------------------------------------|--------------------------|---------------|--------------|------------|
| CT Head/Neck | CT Angiogram | MRI Head/Neck | MR Angiogram | Tilt Table |
| Carotid Doppler | EKG or ECHOCardiogram | Hearing Test | EEG | |
| Electro or VideoNystagmogram | Auditory Evoked Response | Posturography | | |
| Laboratory (i.e., thyroid, glucose) | | | | |

Prior Treatment (Please Circle all that Apply):

Medication Physical Therapy Other (specify) _____

Prior Medications (Please Circle all that Apply):

| | | | | | |
|-----------|--------------------|------------|------------|------------|-----------|
| Aspirin | Chemotherapy Drugs | Tamoxifen | Lasix | Gentamicin | Kanamycin |
| Procardia | Streptomycin | Tobramycin | Vancomycin | Quinine | Quinidine |