Yale Hearing and Balance Center

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DIZZINESS HISTORY

Please complete this questionnaire and bring it with you on the day of your testing.

1. When was the first time you experienced your symptoms?

   _____

   _____

   _____

2. Was the onset of your symptoms sudden and severe or did they come on gradually?

   _____

   _____

   _____

3. Has the frequency and/or intensity of your symptom changed or fluctuated since onset? How?

   _____

   _____

   _____

4. How would you describe your symptom? (For example; lightheadedness, off-balance, spinning, etc)

   _____

   _____

   _____

5. Are your symptoms constant or do they come and go? How long do they last when they are present?

   _____

   _____

   _____

6. Are you completely free of symptoms between attacks? If not, how do you feel between attacks? (For example; tires, unsteady, nauseous, etc)

   _____

   _____

   _____

7. Can you tell when an attack is about the start? How?

_____

_____

_____

8. Do certain head or body movements or position changes seem to cause your symptoms or cause them to change? If so, what types of movements? (For example; walking, bending down, lying down in bed, etc)

_____

_____

_____

9. Do you have any neck, back or leg problems? (For example; herniated disk, knee replacement)

_____

_____

_____

10. Which of these best describe your activity level when your symptoms are worst?
    a) I am able to go on with my usual activities.
    b) I am able to go on with my usually activities using caution.
    c) I am able to go on with only some of my usual activities.
    d) I am unable to go on with most of my usual activities.
    e) I am completely incapacitated and must go to bed.
11. Do you now or have you in the past ever had migraine headaches or other severe headaches?

_____

_____

12. Do you have problem with motion sickness? _____
13. Do certain stimuli cause significant discomfort? (For example; bright lights, loud sounds, strong odors, etc) Please be specific.

_____

_____

14. Please circle any of the symptom or conditions that you currently experience:

hearing loss (R/L)	noise in ears (R/L)	drainage from ears (R/L)
fullness in ears (R/L)	pain in ears (R/L)	pressure in head
blurred vision	blindness	double vision
weakness in arms/legs	numbness in face	numbness in fingers/toes
loss of consciousness	memory loss	rapid heartbeat
shortness of breath	diabetes	allergies
sinus problems	high blood pressure	heart/circulation problems

15. Please circle any of these symptoms or conditions you have experienced in the past:

concussion	skull fracture	whiplash
heart attack	stroke	allergies
sinus problems	mini stroke (TIA)	seizure
thyroid problems	cancer	

16. Please list any major injuries, illnesses or surgeries you have had:

_____

_____

_____

17. Please list all medications you take regularly:

_____

_____

_____

_____

18. Please provide any other information you feel is relevant to your condition:

_____

_____

_____

_____