Riddle Hospital
Main Line Health®

RIDDLE HOSPITAL
AUDIOLOGY
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Health Center 4
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Media, PA 19063

Name: _____ **Date of Birth:** _____

Dizziness Questionnaire

When you're dizzy, do you experience any of the following (please circle all that apply):

Lightheadedness	Objects spin around you	Nausea/vomiting
Blacking out	Spinning Sensation	Pressure in the head
Loss of consciousness	Loss of balance	
Tendency to fall	Headache	

Please answer YES or NO to the following questions:

YES	NO	
___	___	Are you dizzy all the time?
___	___	Can you tell when the dizziness will occur?
___	___	Does a change in position make you dizzy?
___	___	Do you know when your dizziness began?
		If yes, please explain: _____
___	___	Do you know of any possible causes for your dizziness?
		Explain: _____
___	___	Does anything make your dizziness better?
___	___	Does anything make your dizziness worse?
___	___	Did you have a change in medications at the onset of your dizziness?
___	___	Did you ever have a head injury or concussion?
___	___	Do you have allergies?
___	___	Do you use tobacco in any form?
___	___	Are you under stress?

Do you have any of the following ear symptoms? Please answer YES or NO

YES	NO	
___	___	Difficulty hearing? Which ear(s): _____
___	___	Noise in your ears? Which ear(s): _____
___	___	If you have noise in the ears, does it change with dizziness?
___	___	Fullness, stuffiness, or pressure in your ears? Which ear(s): _____
___	___	If you have fullness, stuffiness or pressure does it change with dizziness?
___	___	Pain in your ears? Which ear(s)? _____
___	___	Discharge from your ears? Which ear(s)? _____

Do you have any of the following symptoms? Please answer YES or NO

YES	NO	
___	___	Double vision
___	___	Blurred vision
___	___	Blindness
___	___	Numbness of your face
___	___	Weakness in arms or legs
___	___	Mental confusion
___	___	Loss of consciousness

Is there anything else that you feel may be important for us to know?

_____

_____

_____

_____

_____

_____

FOR OFFICE USE

In the last 48 hours has the patient:

YES	NO	
___	___	Consumed any alcohol, in any form?
___	___	Taken any of the following medications: cold medications, anti-dizziness medications, anti-anxiety medications, antihistamines, sleep aids, or motion sickness medication