Pinnacle ENT ASSOCIATES LLC
VALLEY FORGE EAR, NOSE & THROAT ASSOCIATES DIVISION

Dizziness/Imbalance Questionnaire

Patient Name: _____ Date: ____ / ____ / ____
First MI Last MM DD YYYY

1. Which of these best describes your dizziness? Check only one:
   - ☐ A sensation of movement of yourself or the room: spinning, tilting, or wave-like movement
   - ☐ Light-headedness or feeling that you are going to faint
   - ☐ Loss of balance, unsteadiness
   - ☐ Disorientation with the world, giddiness

2. When you are "dizzy," do you experience any of the following sensations? You may check as many yes responses as necessary.
   - ☐ Yes ☐ No Light-headedness or swimming sensation in the head
   - ☐ Yes ☐ No Blacking out or lack of consciousness
   - ☐ Yes ☐ No Tendency to fall
   - ☐ Yes ☐ No Objects spinning or turning around you
   - ☐ Yes ☐ No Sensation that you are turning or spinning inside
   - ☐ Yes ☐ No Loss of balance when standing or walking
   - ☐ Yes ☐ No Headache
   - ☐ Yes ☐ No Pressure in the head
   - ☐ Yes ☐ No Nausea or vomiting

3. When did the dizziness first occur? _____

4. Is the dizziness CONSTANT or does it come in ATTACKS? _____

5. If the dizziness comes in attacks, how often do these attacks occur?

_____

6. If the dizziness comes in attacks, how often do these attacks last?

_____

7. What factors provoke the dizziness or make the dizziness worse? _____

8. What makes the dizziness better? _____

9. Does your hearing change when the dizziness occurs? ☐ Yes ☐ No

   How? _____ Which ear? ☐ Right ☐ Left

10. Are there any other symptoms associated with the dizziness? Check all that apply:
   - ☐ Blurred vision
   - ☐ Double vision
   - ☐ Numbness or tingling in the arms or legs
   - ☐ Weakness in the arms or legs
   - ☐ Difficulty speaking
   - ☐ Difficulty swallowing

11. Are you completely free of dizziness between attacks? ☐ Yes ☐ No

12. Does blowing your nose, coughing, or lifting heavy objects make you dizzy? ☐ Yes ☐ No

13. Do loud sounds or your own raised voice make you dizzy? ☐ Yes ☐ No

14. Have you ever been diagnosed with a head or neck injury? ☐ Yes ☐ No

If yes, please explain:

_____

_____

_____

15. Do you have any history of neurological diseases such as migraine, multiple sclerosis, or stroke? ☐ Yes ☐ No

If yes, please explain:

_____

_____

16. Do you have any of the following symptoms? Please check 'Yes' or 'No' and check which ear is involved:

☐ Yes ☐ No Difficulty hearing? ☐ Right ☐ Left

☐ Yes ☐ No Noise in your ears (tinnitus)? ☐ Right ☐ Left

☐ Yes ☐ No Does tinnitus change during the dizziness?

If yes, then how? _____

☐ Yes ☐ No Fullness or stuffiness in your ears? ☐ Right ☐ Left