SCOTCH INSTITUTE
ENT| Hearing | Allergy | Sleep

Summergate Professional Center
27406 Cashford Circle
Wesley Chapel, FL 33544
Phone (813) 994-8900
Fax (855) 388-5350

Name: _____
Date: _____ Date of birth: _____

Dizziness Questionnaire

1. **When was the FIRST time you experienced dizziness and what were the circumstances?**
   _____
   _____

2. **When was the LAST time you experienced dizziness?**
   _____

3. **Is your dizziness constant or does it come in spells?**

4. **During your dizziness do you feel like:**

	Yes	No
You are spinning around in circles	☐	☐
The world is spinning around you	☐	☐
You are nauseated	☐	☐
Your head is swimming	☐	☐
You are imbalanced and/or can't walk straight	☐	☐
You are very sensitive to light, or changes in lighting	☐	☐
You are very sensitive to sounds, or changes in sound	☐	☐
If yes: Do sounds make you dizzy?	☐	☐

5. **Your HEARING:**

			If yes, which ear?
Changed for the better recently?	☐	☐	_____
Changed for the worse recently?	☐	☐	_____
Changed during a dizziness attack?	☐	☐	_____

6. **Do your EARS:**

			If yes, which ear?
Ring when you feel dizzy?	☐	☐	_____
Feel full or bursting when you are dizzy?	☐	☐	_____
Feel painful when you are dizzy?	☐	☐	_____

IF your dizziness comes in SPELLS, please answer the following questions (otherwise skip to question 10)

7. **Your typical dizzy spells last: (Please check one)**

Less than 3 mins	☐
More than 3 mins	☐
More than 15 but less than 1 hour	☐
More than 1 hour but less than 12 hours	☐
More than 12 hours but less than 1 week	☐
Weeks to months	☐
Hard to tell, they vary greatly	☐

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8. **How frequently do your dizzy spells occur? (Please check one)**
   - Less than once per month ☐
   - At least once a month, but less than weekly ☐
   - At least once a week, but not daily ☐
   - Daily ☐
   - Varies greatly ☐

9. **Which of the following describes your symptoms?**

	Yes	No	
Dizzy in spells, with break in between	☐	☐	
Dizzy when sitting or standing still	☐	☐	
Dizzy when rolling over in bed	☐	☐	
Dizzy when turning or moving your head	☐	☐	**If yes, which direction?** _____
Dizzy when bending over or reaching down	☐	☐	
Dizziness worsens during menstrual cycle	☐	☐	

10. **Is there anything you can do to make your dizziness go away or lessen in severity?**
    - No ☐
    - Yes ☐ _____

11. **In the last 12 months have you:**

	Yes	No
Fallen? **If yes, how many times?** _____	☐	☐
Lost Consciousness, "blacked out," or fainted?	☐	☐
Had severe prolonged headache/migraines?	☐	☐
Had trouble walking in the dark?	☐	☐
Had any changes in medication?	☐	☐
Gone through menopause?	☐	☐
Had changes to your vision or eyeglass prescription?	☐	☐

12. **Do you have, or have you ever had, any of the following: (check all that apply)**
    - Diabetes ☐
    - Stroke ☐
    - High or low blood pressure ☐
    - Migraine headaches ☐
    - Arthritis ☐
    - Neck/back injury ☐
    - Irregular heartbeat ☐
    - Allergies ☐
    - Cold sores ☐
    - Motion Intolerance ☐

13. **Have you had any previous evaluation for the dizziness (physician exam, imaging, etc)? If so where were you seen and what was ordered?**

_____

_____