Physicians Hearing Care
East Tennessee's Choice For Better Hearing

Name: _____

Please check the appropriate box and fill in the blanks.

When did the symptoms first occur? _____

Yes	No	
☐	☐	My dizziness is CONSTANT
☐	☐	My dizziness is in EPISODES
		If attacks, How Often? _____
		How long do they last? _____
☐	☐	Do you have any warning that it is about to occur?
☐	☐	Are you completely free of dizziness between attacks?
☐	☐	Does the dizziness occur only in certain positions?
☐	☐	Do you have trouble walking in the dark?
☐	☐	When you are dizzy, must you support yourself when standing?
☐	☐	Does your hearing seem to change when you are dizzy?
☐	☐	Do you get dizzy after exertion or overwork?
☐	☐	Were you exposed to any irritating fumes at the onset of dizziness?
☐	☐	Do you know of any possible causes of your dizziness?

Do you know anything that will:

Yes	No	
☐	☐	Stop your dizziness or make it better? _____
☐	☐	Make your dizziness worse? _____
☐	☐	Trigger an attack? _____

When you are having symptoms, do you experience any of the following sensations?

Yes	No	
☐	☐	Lightheadedness
☐	☐	Swimming sensation in the head
☐	☐	Blacking out
☐	☐	Loss of consciousness
☐	☐	Objects spinning or turning around you
☐	☐	You are spinning or turning while outside objects remain stationary Headache
☐	☐	Nausea or Vomiting
☐	☐	Pressure in the head

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Loss of balance while walking:

Yes	No	
☐	☐	Veering to the right
☐	☐	Veering to the left

Tendency to fall:

Yes	No	
☐	☐	To the right
☐	☐	To the left
☐	☐	Backward
☐	☐	Forward

Have you ever experienced any of the following symptoms?

Yes	No			
☐	☐	Double vision	Constant	Episodes
☐	☐	Numbness of face or extremities	Constant	Episodes
☐	☐	Blurred vision or blindness	Constant	Episodes
☐	☐	Weakness/clumsiness in arms or legs	Constant	Episodes
☐	☐	Confusion or loss of consciousness	Constant	Episodes
☐	☐	Difficulty with speech	Constant	Episodes
☐	☐	Tingling around the mouth	Constant	Episodes
☐	☐	Difficulty with swallowing	Constant	Episodes
☐	☐	Spots before eyes	Constant	Episodes

Please check the appropriate box.

Yes	No	
☐	☐	Did you get new glasses recently?
☐	☐	Do you get dizzy when you have not eaten for a long time?
☐	☐	Is your dizziness connected with your menstrual period (if appropriate)?
☐	☐	Have you ever injured your head or neck?
☐	☐	Do you use tobacco in any form?
☐	☐	Do you use alcohol? How much? _____