Otologic Medical Clinic, Inc.
3400 N.W. 56th STREET
OKLAHOMA CITY, OKLAHOMA 73112

NAME ______________________________ DATE ______________

Please answer all questions.

I. When you are "dizzy", do you experience any of the following sensations? PLEASE READ THE ENTIRE LIST FIRST. Then put an "x" in either the first ☐ for YES or in the second ☐ for NO to describe your feelings most accurately.

YES	NO	
☐	☐	1. Lightheadedness
☐	☐	2. Swimming sensation in the head
☐	☐	3. Objects turn around and around you
☐	☐	4. Sensation that everything is floating
☐	☐	5. Loss of balance or tendency to fall: to right, left, forward, backward
☐	☐	6. Loss of consciousness or blacking out
☐	☐	7. Pressure in ears or head

II. Please Check YES or NO ☐ and fill in blank spaces.

YES	NO	
☐	☐	1. My dizziness is constant
☐	☐	2. My dizziness comes in attacks

How often? (estimate and circle one) one time each year, once per month, once per week.

How long do they last? ______________ hours ______________ minutes

When did your first attack occur? ______________________________

____

Tell in your own words what happened ______________________________

____

____

YES	NO	
☐	☐	3. My dizziness has awakened me in the night.
☐	☐	4. Can you tell when an attack is about to start?
☐	☐	5. Are you completely free of dizziness between attacks?
☐	☐	6. Do you have nausea with attacks?
☐	☐	7. Do you have vomiting with attacks?
☐	☐	8. When you are dizzy, can you stand unsupported?
☐	☐	9. Do you know any possible cause for your dizziness?

What? ______________________________

PLEASE COMPLETE OTHER SIDE

(over)

☐ ☐ 10. Does change of position make you dizzy?

☐ ☐ 11. Are you worse in the spring or fall?

☐ ☐ 12. Do you have allergies?

☐ ☐ 13. Have you ever suffered a severe head injury?

☐ ☐ 14. Do you use tobacco? How much? ______________________________

☐ ☐ 15. Do you use alcohol? How much? ______________________________

III. Do you have any of the following symptoms? Check either YES or NO and CIRCLE ear involved.

YES	NO				
☐	☐	1. Difficulty hearing?	Both ears	Right	Left
☐	☐	2. Noise in your ears?	Both ears	Right	Left
		Describe the noise ______________________________			
☐	☐	3. Does the noise change before, after or during times of dizziness?			
☐	☐	4. Fluctuating hearing between better and worse?		Right	Left
☐	☐	5. Do you have pressure or stuffiness in your ears?	Both ears	Right	Left

IV. Please check either YES or NO and CIRCLE either CONSTANT or IN EPISODES.

YES	NO			
☐	☐	1. Double vision?	Constant	In episodes
☐	☐	2. Numbness of face, legs or arms?	Constant	In episodes
☐	☐	3. Blurred vision or blindness?	Constant	In episodes
☐	☐	4. Weakness of arms or legs?	Constant	In episodes
☐	☐	5. Clumsiness in arms or legs?	Constant	In episodes
☐	☐	6. Confusion or loss of consciousness?	Constant	In episodes
☐	☐	7. Difficulty with speech?	Constant	In episodes
☐	☐	8. Difficulty with swallowing?	Constant	In episodes
☐	☐	9. Difficulty walking in dark?	Constant	In episodes

V. Answer YES or NO.

YES	NO			
☐	☐	1. Have you ever had heart trouble?		
☐	☐	2. Do you have high blood pressure?		
☐	☐	3. Have you ever had a stroke?		
☐	☐	4. Have you ever had syphilis?		
☐	☐	5. Do you have diabetes?		
☐	☐	6. Do you suddenly "run out of steam", get jittery or excessively tired in mid-morning, mid-afternoon?		
☐	☐	7. Does food relieve this symptom?	Rapidly	Slowly
☐	☐	8. Have you had water retention before menstrual periods?		
☐	☐	9. Have you ever had thyroid treatments?		

Thank you for your answers. This will greatly help your doctor in his evaluation.