

River Cities Ear, Nose & Throat Specialists

DIZZINESS HISTORY

PATIENT : _____ CONSULTING PHYSICIAN: _____ DATE : _____

CHIEF COMPLAINT:

HISTORY OF PRESENT ILLNESS:

When did your dizziness start? Please be exact (5 days ago etc.) : _____ days _____ weeks _____ months _____ years

How often is your dizziness? : many times a day average once a week at irregular intervals
 average once a day every few months constant

How long do your spells last ? : seconds minutes hours days constant
Are you free from dizziness between spells : yes no

Do you experience any of the following with your dizziness?:

- | | | |
|--|---|---|
| <input type="checkbox"/> Spinning | <input type="checkbox"/> Rolling over to right | <input type="checkbox"/> Being in mall or supermarket |
| <input type="checkbox"/> Light-headed | <input type="checkbox"/> Lying flat | <input type="checkbox"/> Watching traffic |
| <input type="checkbox"/> Staggering to the right | <input type="checkbox"/> Headaches | <input type="checkbox"/> Motion sickness |
| <input type="checkbox"/> Staggering to the left | <input type="checkbox"/> Difficulty walking in the dark | <input type="checkbox"/> Nausea with dizziness |
| <input type="checkbox"/> Looking up | <input type="checkbox"/> Standing from sitting position | <input type="checkbox"/> Vomiting with dizziness |
| <input type="checkbox"/> Bending over | <input type="checkbox"/> Getting out of bed | <input type="checkbox"/> Triggered with watching moving objects |
| <input type="checkbox"/> Rolling over to left | <input type="checkbox"/> Quick movement of the head | <input type="checkbox"/> Cold sweat with spells |
| | | <input type="checkbox"/> Falling |

Do you have any Hearing Loss ? If so , please describe :

<input type="checkbox"/> Right ear:	<input type="checkbox"/> Progressive	<input type="checkbox"/> Sudden	<input type="checkbox"/> Fluctuating	How long _____
<input type="checkbox"/> Left ear:	<input type="checkbox"/> Progressive	<input type="checkbox"/> Sudden	<input type="checkbox"/> Fluctuating	How long _____
Is the hearing loss :	<input type="checkbox"/> More right ear	<input type="checkbox"/> More left ear	<input type="checkbox"/> Equal	

Do you have any Tinnitus? (ringing in the ears):

<input type="checkbox"/> Right ear: Pitch	<input type="checkbox"/> High	<input type="checkbox"/> Low	<input type="checkbox"/> Constant	<input type="checkbox"/> Intermittent	How long _____
<input type="checkbox"/> Left ear: Pitch	<input type="checkbox"/> High	<input type="checkbox"/> Low	<input type="checkbox"/> Constant	<input type="checkbox"/> Intermittent	How long _____
Is the tinnitus :	<input type="checkbox"/> More Right ear	<input type="checkbox"/> More left ear	<input type="checkbox"/> Equal		

Do you have fullness in the ears? If so, please describe :

<input type="checkbox"/> Right ear:	<input type="checkbox"/> Continuous	<input type="checkbox"/> Fluctuating	How long _____
<input type="checkbox"/> Left ear:	<input type="checkbox"/> Continuous	<input type="checkbox"/> Fluctuating	How long _____
Is the fullness:	<input type="checkbox"/> More right ear	<input type="checkbox"/> More left ear	<input type="checkbox"/> Equal

Neurological History :

<input type="checkbox"/> Stroke	<input type="checkbox"/> Headaches	<input type="checkbox"/> Difficulty swallowing	
<input type="checkbox"/> TIA	<input type="checkbox"/> Migraine	<input type="checkbox"/> Difficulty with speech	
<input type="checkbox"/> Seizure	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Confusion	
<input type="checkbox"/> Black out	<input type="checkbox"/> Double vision	<input type="checkbox"/> Memory loss	<input type="checkbox"/> Neck problems

Previous testing & X-rays for Dizziness :

Previous treatment for Dizziness and Treating Doctor :

Doctor Notes: