QLD VESTIBULAR + COCHLEAR CLINIC

AUDIOLOGY SPECIALIST

DIZZINESS QUESTIONNAIRE 1/5

Please submit this questionnaire prior to your appointment

Patient's Details:

Name: _____ DOB: _____

Address: _____ Phone/Mobile: _____

_____ Gender: ☐ Female ☐ Male

The following questions refer to your feeling of dizziness.

Please fill in all the blanks.

Please describe in your own words the off balance/vertigo/ dizzy symptom sensation you CURRENTLY feel without using the word "dizzy". If there are more than one distinct type of sensation please describe both:

_____

_____

_____

_____

_____

Please describe if any significant events which led up to the CURRENT off balance/vertigo/dizzy symptom sensation you feel (eg cold or flu symptoms, flight, head trauma):

_____

_____

_____

_____

_____

If you have had vertigo/dizziness prior to current symptoms please describe if any significant events which led up to THE VERY FIRST initial off balance/vertigo/dizzy symptom sensation ever experienced, even if was years ago (eg cold or flu symptoms, flight, head trauma):

_____

_____

_____

_____

_____

Please describe in your own words the off balance/vertigo/ dizzy symptom sensation you experienced THEN without usingthe word "dizzy". If there are more than one distinct type of sensation please describe both:

_____

_____

_____

_____

_____

Please describe how long the symptoms lasted for and if symptoms changed:

_____

_____

_____

_____

_____

Do you ever have any of the following sensations? Select only those that apply.

☐ Spinning in circles

☐ Falling to one side

☐ World spinning around you

To contact us:

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The following questions refer to typical dizzy spells. Select only those that apply and answer as appropriate.

- [ ] Do your dizzy spells come in attacks?

  How often? _____

  How long do/did the attacks last for? Seconds/ minutes/ hours/days/weeks/months/constant: If more than one type of dizziness describe both:

  _____

  _____

  Date of first spell/attack? _____
- [ ] Are you currently feeling dizzy?
- [ ] Are you free from dizziness between attacks?
- [ ] Are you dizzy or unsteady constantly?
- [ ] Do you get any warning the dizziness is about to start?

  What are the warning signs?

  _____
- [ ] Are you dizzy at certain times of the day or night?

  If so which? _____
- [ ] Did you take any medications (inc strong antibiotics, more than one type of dizziness describe both:

  If yes what were they?

  _____

  _____
- [ ] Did you have any cold or flu like symptoms prior to onset?
- [ ] Does your hearing change with an attack?
- [ ] Do you only get dizzy when you move?
- [ ] Are you dizzy mainly when you sit or stand up quickly?
- [ ] Are you dizzy when you look up, down or bend forward or backwards?

  If so which? _____
- [ ] Are you dizzy if you roll over in bed?

  If so in the right or left side? _____
- [ ] Are you dizzier in certain positions?

  Which position?

  _____
- [ ] Are you nauseated during an attack?
- [ ] Are you dizzy even when lying down?
- [ ] Does closing your eyes make your dizziness worse?
- [ ] Are you better if you sit or lie perfectly still?
- [ ] Have you had a recent cold or flu preceding recent dizz spells?
- [ ] Have you had fullness, pressure, or ringing in your ears?
- [ ] Have you had pain or discharge in your ear of recent onset?
- [ ] Do you have a loss of balance when walking in dark?

  If so veering to the right or left? _____
- [ ] Do you have a loss of balance when walking in the light?

  If so veering to the right or left? _____
- [ ] Do loud sounds make you dizzy?
- [ ] Do you get dizzy when you cough, sneeze, blow nose, bowel movement or other?

  If so which?

  _____
- [ ] Are your symptoms exacerbated or initiated when in upright posture eg. standing or sitting?

  _____
- [ ] Are your symptoms exacerbated or initiated when in motion eg. walking, driving, flying etc?

  _____
- [ ] Are your symptoms exacerbated or initiated when not in motion but visual stimuli gives impression of moving (eg. sitting in car and cars beside you move giving sensation of movement)?

  _____
- [ ] Are your symptoms exacerbated or initiated with seeing moving objects or complex visua with seeing moving objects or complex visual images, patterned carpets, clothes or pictures)?

  _____

Any other comments about your dizziness you feel is pertinent?

_____

_____

_____

_____

The following refer to other sensations you may have. Select only those that apply and answer as appropriate.

- ☐ Do you black out or faint when dizzy?

Have you had:

- ☐ Severe or recurrent headaches or migraines?
- ☐ Light and/or sound sensitivity leading up to or during your headaches or dizziness/vertigo?
- ☐ Visual Auras (eg. lines, spots, squiggles) leading up to or during your headaches or dizziness/vertigo?
- ☐ Any double or blurry vision?
- ☐ Numbness in your face, ears or extremities? If so both sides, left or right? _____
- ☐ Weakness or clumsiness in arms, legs?
- ☐ Pain in the neck or shoulders?
- ☐ Slurred or difficult speech?
- ☐ Difficulty swallowing?
- ☐ Tingling around your mouth?
- ☐ Spots before your eyes?
- ☐ Jerking of arms or legs?
- ☐ Seizures?
- ☐ Confusion or memory loss?
- ☐ Recent head trauma? (If yes, please explain).

_____

_____

Any other sensation variables you feel are pertinent to your condition?

_____

_____

_____

_____

The following refers to your hearing. Select only those that apply and indicate which side has been affected:

- ☐ Difficulty hearing in one ear?
  - ☐ Left ☐ Right ☐ Both
- ☐ Ringing or buzzing in one ear?
  - ☐ Left ☐ Right ☐ Both
- ☐ Fullness in one ear?
  - ☐ Left ☐ Right ☐ Both
- ☐ Change in hearing and tinnitus volume when dizzy?
- ☐ Does your hearing fluctuate?
- ☐ Can you hear your heartbeat, eyes blinking, or any other internal sounds? Which sound and which ears?

  _____
  - ☐ Left ☐ Right ☐ Both
- ☐ Own voice excessively loud?
  - ☐ Left ☐ Right ☐ Both

Any other variables to do with your hearing you feel are pertinent?:

_____

_____

_____

_____

Have you had any of the following?

- ☐ Pain in ears?
  - ☐ Left ☐ Right ☐ Both
- ☐ Discharge from ears?
  - ☐ Left ☐ Right ☐ Both
- ☐ Hearing change for the better?
  - ☐ Left ☐ Right ☐ Both
- ☐ Hearing change for the worse?
  - ☐ Left ☐ Right ☐ Both
- ☐ Exposure to loud noises?
- ☐ Previous ear infections?
- ☐ Trauma to your ear(s)?
- ☐ Previous ear surgery?

  What? _____
- ☐ Family history of deafness?

The following refer to habits and lifestyle. Select only those that apply and answer as appropriate.

- ☐ Is there added stress to your life recently?

Is your dizziness related to:

- ☐ Moments of stress?
- ☐ Menstrual period?
- ☐ Overwork or exertion?
- ☐ Hunger?
- ☐ Emotional upset?
- ☐ Changes in weather/atmospheric pressure?
- ☐ Do you feel light-headed or have a swimming sensation when you are dizzy?
- ☐ Do you find yourself breathing faster or deeper when excited or dizzy?
- ☐ Did you recently change eyeglasses?
- ☐ Have you ever had weakness or faintness a few hours after eating?

Is your dizziness related to any of the following?

- ☐ Do you drink coffee?
  How much and how often? _____
- ☐ Do you drink tea?
  How much and how often? _____
- ☐ Do you drink soft drinks?
  How much and how often? _____
- ☐ Do you drink alcohol?
  How much and how often? _____
- ☐ Do you smoke?
  What? _____
  How much and how often? _____

Describe any other variables you feel may contribute to your dizziness:

_____
_____
_____
_____

Past medical history

Please list your current medical problems and length of illness:

_____
_____
_____
_____

Please list all surgery performed and approximate dates:

_____
_____
_____
_____

Please list all allergies (including drugs) and reaction:

_____
_____
_____
_____

Please list all medicines you currently take for your dizziness that HAVE provided some relief or benefit with your symptoms:

_____
_____
_____
_____

Please list all medicines you currently take for your dizziness that HAVE NOT provided some relief or benefit for you:

_____
_____
_____
_____

Please list all medicines you currently take (including pain medicine, nonprescription medicine, nerve pills, sleeping pills, or birth control pills).

_____
_____
_____
_____

Have you had any previous testing eg hearing, x-rays, head scans, etc?

_____
_____
_____
_____

Family history

Any family history of any of the following?
Select all that apply.

- ☐ Migraine?
- ☐ Off balance/vertigo/dizziness or tinnitus?
- ☐ High blood pressure?
- ☐ Low blood pressure?
- ☐ Diabetes?
- ☐ Low blood sugar?
- ☐ Thyroid disease?
- ☐ Asthma?
- ☐ Multiple Sclerosis?

Please list any other diseases that run in your immediate family:

Any other comments you feel are pertinent to your condition:

Declaration

I confirm that for my appointment I will:

- ☐ Not wear make-up
- ☐ Not eat anything for 8 hours prior
- ☐ Have no caffeine for 12 hours prior
- ☐ Have no alcohol for 48 hours prior
- ☐ Have no nicotine (cigarettes, gum, patches etc) for 12 hours prior
- ☐ Not take - tranquilisers, sedatives, vestibular suppressants (eg Stemetil, Serc) and painkillers for 24 hours prior
- ☐ All information on this form is true and accurate and I consent to the use of any data/results to be used anonymously for research purposes

Signature

Submit via email

Please complete and sign this questionnaire and submit to

Email: contact@qvcc.com.au