Otolaryngology - Head & Neck, Facial, Plastic & Reconstructive Surgery

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Vestibular Evaluation Questionnaire

DATE: ________________________

PATIENT NAME: ______________________________________ DOB: __/__/_____ CHART #: _______________

1. **Please describe, in your own words, the sensation you feel without using the word "dizzy":**

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2. **Do you ever have any of the following sensations?:**

Yes No Spinning in circles?
Yes No Falling to one side?
Yes No World spinning around you?

3. **Does the following refer to a typical dizzy spell?:**

Yes No Do the dizzy spells come in attacks?
How often? ______________________________________
How long? _______________________________________
Date of first spell? __________________
Yes No Are you free from dizziness between attacks?
Yes No Does your hearing change with an attack?
Yes No Are you dizzy in certain positions?
Which position? __________________________________
Yes No Are you nauseated during an attack?
Yes No Are you dizzy even when lying down?
Yes No Had a recent cold or flu preceding recent dizzy spells?
Yes No Fullness or pressure or ringing in your ears?
Yes No Pain or discharge in your ear of recent onset?

Yes No Trouble walking in the dark?
Yes No Are you better if you sit or lie perfectly still?

4. Does the following refer to other sensations you might have?:

Yes No Do you black out or faint when you are dizzy?
Yes No Are you dizzy or unsteady constantly?
Yes No Do you have severe or recurrent headaches?
Yes No Any double or blurry vision?
Yes No Numbness in your face or extremities?
Yes No Slurred or difficult speech?
Yes No Difficulty swallowing?
Yes No Tingling around your mouth?
Yes No Spots before your eyes?
Yes No Jerking of arms or legs?
Yes No Head injury or loss of consciousness?
Yes No Confusion or memory loss?

5. Does the following refer to your hearing?

Yes No Difficulty hearing in one ear? L R
Yes No Ringing in one ear? L R
Yes No Fullness in one ear? L R
Yes No Change in hearing when dizzy?
How? ______________________________
Yes No Exposure to loud noises?
Yes No Previous ear infections?
Yes No Previous ear surgery?
What type? _______________ When? _______________
Yes No Family history of deafness?
Yes No Pain in ears? L R
Yes No Discharge from ears? L R
Yes No Hearing changes? L R
Yes No Better? L R
Yes No Worse? L R

6. Does the following refer to your habits and lifestyle?:

Yes No Is there added stress in your life recently?

Is your dizziness related to:
Yes No Moments of stress?
Yes No (If female) Menstrual period?
Yes No Overwork or exertion?
Yes No Do you feel lightheaded or have a swimming sensation when dizzy?
Yes No Do you find yourself breathing faster or deeper when excited or dizzy?
Yes No Did you recently change eyeglasses?
Yes No Do you drink coffee? How much? _______________________
Yes No Do you drink tea? How much? _______________________

General Business

Yes No Do you drink soft drinks? How much? ______________________

Yes No Do you drink alcohol? How much? ______________________

Yes No Do you smoke? What? ________ How much? ________________

7. **Medical history: Please list your current medical problems and length of illness on the office information form.**
8. **Surgery: Please list all surgeries performed and approx. dates on office information form.**
9. **Medicines: Please list all medications you currently take (including pain medications, non-prescription medicines, nerve pills, sleeping pills, and birth control pills) on the office information form.**
10. **What studies have been done previously (e.g., hearing, radiographs, head scans)?**
11. **Miscellaneous:**

Yes No Are you allergic to any medications? What? ________________

Yes No Are you allergic to anything? What? ______________________

Yes No Ever had weakness or faintness a few hours after eating?

Yes No Are you dizzy mainly when you sit stand up quickly?

Yes No High blood pressure?

Yes No Low blood pressure?

Yes No Diabetes?

Yes No Low blood sugar?

Yes No Thyroid disease?

Yes No Asthma?

12. **Do you have anything else to tell us about your particular problem that we have not asked you on this questionnaire?**

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