



# CALIFORNIA EAR INSTITUTE

## DIZZINESS QUESTIONNAIRE

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

You have indicated you have vertigo, imbalance or dizziness problems. Answer the following questions by circling the appropriate bold response or answering in the blank space provided.

- My first attack occurred \_\_\_\_\_. My most recent attack occurred \_\_\_\_\_.
- I can / cannot tell an attack is about to begin. If you can tell, how far ahead can you tell \_\_\_\_\_.
- Which of the following most closely resembles your problem? Mark as many as apply.
  - A whirling or spinning sensation where your surroundings, you, or both move.
  - Imbalance without a sensation of motion that:
    - Causes a rocking sensation.
    - Makes you feel like you veer or are pushed to one side.
    - Makes you feel like you need extra support.
  - A sense of lightheadedness, giddiness, head swimming, floating.
  - None of the above, more like \_\_\_\_\_.
- I have dizziness all of the time / some of the time / once in a while. Symptoms are constant / fluctuate.
- I have / do not have isolated attacks of vertigo that come \_\_\_\_\_ times a week / month / year.
- When attacks occur, the sensation of motion lasts on the average \_\_\_\_\_ minutes / hours / days. It takes \_\_\_\_\_ minutes / hours / days for me to completely regain my balance after the motion ceases.
- When my balance disturbance is disturbed, I have: *(please circle)*

Ear Ringing	Ear Fullness	Ear Pressure	Hearing Changes	Sound Distortion	
Headache	Visual Changes	Numbness/Tingling	Darkening Vision	Ear Pain	
Ear Discharge	Nausea	Vomiting	Problem Working	Difficulty Walkin	Unconsciousness
Falling	Other: _____				
- What triggers dizziness: \_\_\_\_\_.
- What makes it worse: \_\_\_\_\_.
- What makes it better: \_\_\_\_\_.
- My dizziness seems / does not seem to be worse at a particular time of year.
- Certain foods do / do not trigger or exacerbate my symptoms.
- Number of MD's seen: \_\_\_\_\_ Family MD/Internal Medicine \_\_\_\_\_ Neurologist \_\_\_\_\_ ENT/Ear Specialist  
*Please give additional information about any of the following tests that you have had.*

Test Type	Date/Result	Test Type	Date/Result
CT Scans		Audiogram	
MRI scan		ENG	
Ultrasound		ABR	
Posturography		EcoG	

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