Dizzy Evaluation

Name: _____ **Date:_____**

When did your dizziness first occur?_____

Is you dizziness constant or does it come in spells? (PICK ONE)

It is constant……..☐

It comes in spells……☐

A. If it comes in spells:

a. My dizzy attack lasts (pick ONE):

Minutes…… ☐
Hours…… ☐
Days…… ☐
Weeks…… ☐
Varies greatly…… ☐

Usually, an attack happens (pick ONE):

Less than once a month…… ☐
At least once a month…… ☐
At least once a day…… ☐
Daily…… ☐
Varies greatly…… ☐

B. Check YES or NO and Specify if indicated	**YES**	**NO**
1. Does change of position make you dizzy?	☐	☐
2. Do you know anything that will:		
a. Cause an attack?	☐	☐
b. Stop your dizziness or make it better?	☐	☐
c. Make your dizziness worse?	☐	☐
C. When dizzy, do you experience any of the following?		
1. Lightheadedness	☐	☐
2. Objects spinning around you	☐	☐
3. Tendency to fall.	☐	☐
a. Which Way?_____		
4. Loss of balance when walking	☐	☐
a. To the right or left?_____		
5. Headache	☐	☐
6. Nausea or vomiting	☐	☐
7. Pressure in the head	☐	☐

D. Do you experience any of the following (circle all answers) ?

1. Difficulty in hearing	Yes	No	Both ears	Right	Left
a. Does your hearing fluctuate?	Yes	No	Both ears	Right	Left
2. Noise in your ears	Yes	No	Both ears	Right	Left
a. Describe:_____					
3. Fullness in your ears	Yes	No	Both ears	Right	Left
4. Pain in your ears	Yes	No	Both ears	Right	Left
5. Discharge from your ears	Yes	No	Both ears	Right	Left

E. Do you experience any of the following (circle all answers)?

1. Double vision	Yes	No	Constant	In Episodes
2. Numbness of face or extremities	Yes	No	Constant	In Episodes

3.	Blindness	Yes	No	Constant	In Episodes
4.	Weakness in arms or legs	Yes	No	Constant	In Episodes
5.	Confusion or loss of consciousness	Yes	No		
6.	Difficulty with speech	Yes	No		
7.	Difficulty with swallowing	Yes	No		

F. Head Injury- Check YES or NA and specify if indicated	**YES**	**NO**
1. Have you ever been knocked unconscious?	☐	☐
a. If yes, How?_____		
2. Do you have or have you ever had any of the following?		
a. Skull Fracture	☐	☐
b. Neck Injury	☐	☐
c. Eye Problems	☐	☐
G. Neuropathy		
a. Have you had numbness of your feet	☐	☐
b. Have you had a stroke	☐	☐
c. Have you had loss of vision	☐	☐