

### DIZZY QUESTIONNAIRE

NAME:	DATE:
OFFICE: <input type="checkbox"/> ANNAPOLIS <input type="checkbox"/> COLUMBIA <input type="checkbox"/> GLEN BURNIE <input type="checkbox"/> KENT ISLAND <input type="checkbox"/> LAUREL <input type="checkbox"/> ODENTON	DOCTOR: <input type="checkbox"/> BENINGFIELD <input type="checkbox"/> CHANG <input type="checkbox"/> BUCHALTER <input type="checkbox"/> HAMBURGER <input type="checkbox"/> LEE <input type="checkbox"/> LISK <input type="checkbox"/> MARCUS <input type="checkbox"/> PACHECO

**CHECK OFF OR FILL IN ALL ITEMS THAT APPLY**

DOES DIZZINESS FEEL LIKE	ASSOCIATED EAR SYMPTOMS	TIME PERIOD	PAST HISTORY
<input type="checkbox"/> Motion <input type="checkbox"/> Spinning <input type="checkbox"/> Turning <input type="checkbox"/> Falling <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Forward <input type="checkbox"/> Backward <input type="checkbox"/> Lightheaded <input type="checkbox"/> Faintness <input type="checkbox"/> Wooziness  <input type="checkbox"/> Other _____	SYMPTOMS <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Popping in Ears <input type="checkbox"/> Fullness or Pressure <input type="checkbox"/> Hearing Loss  WHICH EAR <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both  OTHER ASSOCIATED SYMPTOMS <input type="checkbox"/> Nausea/Vomiting  <input type="checkbox"/> Headache <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Weakness or numbness of Arms, legs, or face <input type="checkbox"/> Visual Disturbance <input type="checkbox"/> Difficulty with speech	First time dizzy _____  How often _____  Lasts how long: <input type="checkbox"/> _____seconds <input type="checkbox"/> _____minutes <input type="checkbox"/> _____hours <input type="checkbox"/> _____days  Last episode _____  <input type="checkbox"/> Warning before attack starts <input type="checkbox"/> Free of dizziness between Attacks  <input type="checkbox"/> Time of day: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Bedtime <input type="checkbox"/> Awaken from sleep	<input type="checkbox"/> Head Injury <input type="checkbox"/> Ear Injury <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Scuba Diving <input type="checkbox"/> Ear Surgery <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Sinus trouble <input type="checkbox"/> Allergies <input type="checkbox"/> Stroke <input type="checkbox"/> Diabetes <input type="checkbox"/> Abnormal Heart Beat <input type="checkbox"/> Circulation problem <input type="checkbox"/> Syphilis <input type="checkbox"/> Thyroid Disease

<b>What improves your dizziness</b> <input type="checkbox"/> Eyes open <input type="checkbox"/> Eyes closes <input type="checkbox"/> Lying Down <input type="checkbox"/> Medication _____  <input type="checkbox"/> Other _____	<b>What makes your dizziness worse?</b> <input type="checkbox"/> Head movements <input type="checkbox"/> Getting up from sitting or lying position <input type="checkbox"/> Fatigue <input type="checkbox"/> Hunger <input type="checkbox"/> Exertion <input type="checkbox"/> Menstrual Period <input type="checkbox"/> Stress <input type="checkbox"/> Irritating Fumes <input type="checkbox"/> Other _____
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Comments: