EAR, NOSE AND THROAT ASSOCIATES OF CHESTER COUNTY

DIZZINESS AND BALANCE STUDY

NAME:___________________________________ DATE:_________________

PLEASE ANSWER ALL QUESTIONS

1. When was your first attack? ______________________________________

2. Describe what you are experiencing.
   Spinning Lightheaded Passing out Drunk feeling Off balance
   Other_______________

3. How long does your dizziness last?
   Few seconds Seconds to minutes Minutes to several hours
   Hours to days Continuous Other________________________

4. How often do you get dizzy?
   Only once More than once Frequency__________________

5. Do any of the following provoke your attacks?
   Standing up Head movements Loud sounds Sneezing Straining
   Rolling over in bed Stress Diet Other_______________________

6. What makes your dizziness better? ____

7. What makes your dizziness worse? ____

8. Do you have difficulty walking in the dark? Yes No

9. Has the dizziness changed since the first episode? Yes No
   If yes: Better – Worse Shorter – Longer

10. Do you have any of the following symptoms? Please mark and CIRCLE the ear(s) involved.

YES	NO					
___	___	1.	Difficulty in hearing?	Both ears	Right	Left
___	___	2.	Fluctuating hearing loss?	Both ears	Right	Left
___	___	3.	Noise in your ears?	Both ears	Right	Left
			Describe the noise_______________________________________			
			Does the noise change with dizziness? ___ If so, how?_________			
			____			
___	___	4.	Fullness or stuffiness in your ears?	Both ears	Right	Left
___	___	5.	Pain in your ears?	Both ears	Right	Left
___	___	6.	Discharge from your ears?	Both ears	Right	Left

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11. Have you ever had any of the following?

Intravenous antibiotics	Radiation therapy	Ear surgery
Chemotherapy	Syphilis	Noise exposure

12. Have you experienced any of the following symptoms? Please mark and circle either CONSTANT or IN EPISODES to describe your feelings most accurately.

YES	NO				
___	___	1.	Double vision	Constant	In episodes
___	___	2.	Numbness of face or extremities	Constant	In episodes
___	___	3.	Blurred vision or blindness	Constant	In episodes
___	___	4.	Arms or legs weak	Constant	In episodes
___	___	5.	Arms or legs clumsy	Constant	In episodes
___	___	6.	Confusion or loss of consciousness	Constant	In episodes
___	___	7.	Difficulty with speech	Constant	In episodes
___	___	8.	Difficulty swallowing	Constant	In episodes

13. Do you have any of the following medical problems?

Diabetes Strokes Hypertension Coronary artery disease
Visual difficulty Seizures Migraines Psychiatric disease________________
Allergies Please list____

14. What medications are you currently taking? __________________________________
____

15. The level of my disability from dizziness is best described as:

___ I am able to work, drive, and feel no ill effects from my dizziness.
___ I can continue to function with my dizziness but not optimally.
___ I need to stop when dizzy but can return to work soon thereafter.
___ I am incapacitated for extended periods of times because of the dizziness.
___ I am unable to leave the house.
___ I am disabled.

16. Does anyone in the family have:

Migraines Meniere's disease Neurologic disorder Anxiety/Depression
Hearing loss

17. If there is any other additional information that you consider important in describing your "dizziness", please enter below.

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