



Circle the word that best describes your symptom: Disequilibrium, giddiness, unsteadiness, imbalance, vertigo, light headedness, etc.

Describe your symptom: _____

- Dizziness began: _____ days / weeks / months / years ago OR specific date: ___ / ___ / ____.

- How often does it happen? _____ Per day / week / month / year // most or all the time

- How long does it last? _____ seconds / minutes / hours

- Do you have ear symptoms such as: ear pressure, ear pain, discharge from ear, ringing in the ear or hearing loss.

- Dizziness occurs while moving / standing stationary / sitting.

- Did you have an attack of fairly severe dizziness lasting 3-7 days at the onset? Y / N

- Is there an associated headache? Yes / No, If yes: it is preceded by / followed by / not related to dizziness.

- Have you developed numbness / tingling / weakness in your legs?

- Dizziness is exacerbated by:

any motion	bending over	head back	lying down
rolling in bed to left	rolling in bed to right	standing up	turning head

- Dizziness began following:

head injury	fall	car accident	viral infection
meningitis	stroke	high fever	ear infection
ear surgery	heart surgery	vaccination	drug reaction

- Which medications have you tried for dizziness? :

Meclizine Antivert Plavix Aspirin Coumadin Valium Ativan Xanax Sudafed

- What type of work up / tests / consults have you done so far?

CT scans (brain/sinuses) MRI (brain, cervical spine) VNG (vestibule-nystagmogram)
EKG Holter Monitoring ECHO ENT evaluation
Cardiology evaluation other

- Are you taking any new medications? ? (circle): Yes / No, If yes, which: _____

- Are you going through any major life event / stressful situation? ? (circle): Yes / No, If yes, describe: _____

- Is there anything you would like to add about your dizziness? _____

- What are you most worried about with your dizziness? _____