Maria M. Doucet, M.D.

EVALUATION FOR DIZZINESS

Patient Name: _____ Date: _____
Date of Birth: _____

- When did your dizziness first occur?

- Is your dizziness constant or does it occur in attacks?

- When you are dizzy, do you experience any of the following sensations? (Please circle all that apply.)
  Spinning sensation while objects around you remain stationary
  Lightheadedness
  Swimming sensation in head
  Feeling as if you might black out
  Loss of consciousness
  Pressure in head or ears
  Objects spinning around you
  Headaches
  Imbalance while walking
  Tendency to fall
  Tendency to veer left or right while walking

- How long does your dizziness last? Please circle one of the following:
  SECONDS MINUTES HOURS DAYS

- Does anything make your dizziness better or worse? If so, please explain.

- Does your dizziness occur in certain positions or places? If so, please explain.

- Are you completely free of dizziness between attacks? YES NO

- Do you have trouble walking in the dark? YES NO

- Have you ever had a stroke or TIA? If so, when? YES NO

- Have you ever experienced any of the following symptoms? Please check YES or NO; if you answer YES, please indicate whether the symptoms are CONSTANT or occur in EPISODES.

YES	NO		CONSTANT	EPISODES
		Double Vision		
		Numbness of face or extremities		
		Blurred vision or blindness		
		Weakness in arms or legs		
		Clumsiness of arms or legs		
		Confusion or loss of consciousness		
		Difficulty with speech		
		Difficulty with swallowing		
		Tingling in or around the mouth		
		Seeing spots before the eyes		

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- Do you have any of the following symptoms or problems with your ears? Please check YES or NO and select the ear involved.

YES	NO		LEFT EAR	RIGHT EAR
		Difficulty hearing		
		Noises (ringing, etc.) in your ears		
		Pain in your ears		
		Pressure or fullness in your ears		
		Discharge or drainage from your ears		
		Ear surgery		

- Please check either YES or NO.

	YES	NO
Do you get dizzy after exertion or overwork?		
Did you recently get a new eyewear prescription?		
Do you tend to get upset or anxious easily?		
Do you get dizzy or lightheaded when you have not eaten for a long time?		
Have you ever had a neck or back injury?		
Have you ever had a head injury that rendered you unconscious?		
Were you exposed to any irritating fumes, paints, etc. at the onset of your dizziness?		
Do you use tobacco in any form? If so, how much and how often?		
Do you use alcohol?		
Do you have any allergies? If so, please list below:		
Do you take any medications regularly? If so, please list below:		

Reviewed: _____
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