Questionnaire for the Dizzy Patient

Briefly describe your dizzy spell: _____

_____

_____

Do you experience more than 30 minutes of continuous spinning sensations? [ ] Yes [ ] No

Do you have:

A headache	[ ] Yes [ ] No
Diabetes	[ ] Yes [ ] No
Thyroid disease	[ ] Yes [ ] No
Environmental allergies	[ ] Yes [ ] No
Fullness in one or both ears	[ ] Yes [ ] No
Fluctuating hearing loss (hearing that comes and goes)	[ ] Yes [ ] No
Pressure in one or both ears	[ ] Yes [ ] No
Ringing in one or both ears	[ ] Yes [ ] No

Have you been exposed to any venereal disease to your knowledge? [ ] Yes [ ] No

Have you ever had head trauma where you were unconscious? [ ] Yes [ ] No

Do you smoke? [ ] Yes [ ] No

What medications are you taking? _____

_____

_____

Name: _____ Date: _____