Ear, Nose, Throat - Head & Neck Surgery
of Huntsville

Otolaryngology - Head & Neck, Facial, Plastic & Reconstructive Surgery

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Vestibular Evaluation Questionnaire

NAME: _____ DATE: _____

1. **Please describe, in your own words, the sensation you feel without using the word "dizzy":**

   _____

   _____

2. **Do you ever have any of the following sensations?:**

Yes	No	Spinning in circles?
Yes	No	Falling to one side?
Yes	No	World spinning around you?

3. **Does the following refer to a typical dizzy spell?:**

Yes	No	Do the dizzy spells com in attacks?
		How often? _____
		How long? _____
		Date of first spell? _____
Yes	No	Are you free from dizziness between attacks?
Yes	No	Does your hearing change with an attack?
Yes	No	Are you dizzy in certain positions?
		Which position? _____
Yes	No	Are you nauseated during an attack?
Yes	No	Are you dizzy even when lying down?
Yes	No	Had a recent cold or flu preceding recent dizzy spells?
Yes	No	Fullness or pressure or ringing in your ears?
Yes	No	Pain or discharge in your ear of recent onset?
Yes	No	Trouble walking in the dark?
Yes	No	Are you better if you sit or lie perfectly still?

4. Does the following refer to other sensations you might have?:

Yes No Do you black out or faint when you are dizzy?
Yes No Are you dizzy or unsteady constantly?
Yes No Do you have severe or recurrent headaches?
Yes No Any double or blurry vision?
Yes No Numbness in your face or extremities?
Yes No Slurred or difficult speech?
Yes No Difficulty swallowing?
Yes No Tingling around your mouth?
Yes No Spots before your eyes?
Yes No Jerking of arms or legs?
Yes No Head injury or loss of consciousness?
Yes No Confusion or memory loss?

5. Does the following refer to your hearing?

Yes No Difficulty hearing in one ear? L R
Yes No Ringing in one ear? L R
Yes No Fullness in one ear? L R
Yes No Change in hearing when dizzy?
How? _____
Yes No Exposure to loud noises?
Yes No Previous ear infections?
Yes No Previous ear surgery?
What type? _____ When? _____
Yes No Family history of deafness?
Yes No Pain in ears? L R
Yes No Discharge from ears? L R
Yes No Hearing changes? L R
Yes No Better? L R
Yes No Worse? L R

6. Does the following refer to your habits and lifestyle?:

Yes No Is there added stress in your life recently?

Is your dizziness related to:
Yes No Moments of stress?
Yes No (If female) Menstrual period?
Yes No Overwork or exertion?
Yes No Do you feel lightheaded or have a swimming sensation when dizzy?
Yes No Do you find yourself breathing faster or deeper when excited or dizzy?
Yes No Did you recently change eyeglasses?
Yes No Do you drink coffee? How much? _____
Yes No Do you drink tea? How much? _____
Yes No Do you drink soft drinks? How much? _____
Yes No Do you drink alcohol? How much? _____
Yes No Do you smoke? What? _____ How much? _____

7. Medical history: Please list your current medical problems and length of illness on the office information form.

8. **Surgery: Please list all surgeries performed and approx. dates on office information form.**
9. **Medicines: Please list all medications you currently take (including pain medications, non-prescription medicines, nerve pills, sleeping pills, and birth control pills) on the office information form.**
10. **What studies have been done previously (e.g., hearing, radiographs, head scans)?**
11. **Miscellaneous:**

Yes	No	Are you allergic to any medications? What? _____
Yes	No	Are you allergic to anything? What? _____
Yes	No	Ever had weakness or faintness a few hours after eating?
Yes	No	Are you dizzy mainly when you sit stand up quickly?
Yes	No	High blood pressure?
Yes	No	Low blood pressure?
Yes	No	Diabetes?
Yes	No	Low blood sugar?
Yes	No	Thyroid disease?
Yes	No	Asthma?

12. **Do you have anything else to tell us about your particular problem that we have not asked you on this questionnaire?**

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