Carole M. Dean, M.D., P.C.

5555 Peachtree Dunwoody Rd. Suite 256
Atlanta, GA 30342

Email: dr.dean@thevoiceinstitute.net
www.TheVoiceInstitute.net

Phone: 404-252-7557
Fax: 404-252-7551

PATIENT HISTORY: DIZZINESS

Name: _____ Age: _____ Date: _____

1. When did you first develop dizziness?

2. What is it like? (Please check all that apply)

_____ a. Lightheadedness

_____ b. Blacking out (loss of consciousness)

_____ c. Tendency to fall. If yes, which direction:

_____ right _____ left

_____ forward _____ backward

_____ d. Objects spinning or turning around you (eyes open)

_____ e. Sensation that you are turning or spinning inside (eyes closed)

_____ f. If yes to sensations "d" or "e", indicate the direction of motion.

_____ to right _____ to left

_____ g. Loss of balance

_____ h. Nausea or vomiting

PLEASE CHECK THE APPROPRIATE RESPONSE AND FILL IN THE BLANK SPACES.

3. My dizziness is:

_____ Constant

_____ Episodic

4. If episodic, how long do the attacks last? _____

   How often do you have the attacks? _____

   Have they been more/less frequent recently? _____

   More or less severe? _____

5. When did your dizziness first occur? _____

6. What were you doing at the time? _____

7. Yes / No An infection like "the flu", "a cold", "cold sores" or other herpes infections or "sinus" during the two months prior to your dizziness? Described briefly:

PLEASE CHECK ALL THAT APPLY.

8. _____ Completely free of dizziness between attacks

9. _____ Dizziness rolling over in bed

   _____ to right _____ to left

10. _____ Dizziness with change of position.

    What kind of position change?

11. _____ Dizziness only occurring in certain positions. If so, please indicate:

    _____ Upright _____ Turning to right

    _____ Lying flat _____ Turning to left

12. _____ Dizziness from

    _____ Bending

    _____ Lifting

    _____ Forceful nose blowing

13. _____ Trouble walking in the dark

14. _____ Know of any possible cause of your dizziness

If so, please describe:

15. _____ Anything that will stop your dizziness or make it better

If so, please describe:

16. _____ Anything that will bring on an attack or make your dizziness worse

_____ Fatigue _____ Certain foods

_____ Exertion _____ Menstrual

_____ Hunger _____ Other

17. _____ Any warning sign that an attack is about to start

_____ Yes _____ No

18. _____ Once an attack has begun, does head movement make it worse?

_____ Yes _____ No

19. _____ Significant difficulty with motion sickness now or in the past?

20. _____ Headaches in relation to the attack

21. _____ Migraine headaches

_____ Other members of your family with migraine headaches. Describe:

PLEASE CHECK ANY OF THE SYMPTOMS THAT APPLY AND INDICATE WHICH EAR BY CIRCLING LETTER.

22. _____ Does your hearing change when you are dizzy? R L Both

_____ Hearing loss? R L Both

23. _____ Do you have ear noises? R L Both

_____ Constant _____ Ringing

_____ Episodic _____ Buzzing

(If you have ear noises, please complete Tinnitus form)

_____ Do they change with dizziness? R L Both

_____ Do you have ear fullness or stuffiness? R L Both

_____ Does this change when you are dizzy? R L Both

_____ Worse _____ Better R L Both

_____ Worse _____ Better R L Both

_____ Have you ever injured your head? R L Both

_____ Unconscious _____ Bleeding from ear

_____ Hit directly in ear

_____ Have you ever injured your neck? R L Both

_____ Do you have spine disease like arthritis (especially in the neck)?

_____ Yes _____ No

_____ What drugs (if any) have been used to treat your dizziness?

If you have hearing loss, please ask for the Hearing Loss History Form
If you are troubled by ear noises, please ask for the Tinnitus History Form