Dr. Michael Freedman

Ear, Nose, Throat, Allergies & Facial Plastic Surgery

Dizziness Questionnaire

Patient Name: _____

Please describe your dizziness: _____

_____

When did your dizziness start? _____

Did you experience a severe first episode of dizziness? _____

If so, when? _____

Is your dizziness constant or intermittent? _____

If intermittent, how long are the episodes? _____

How often do they occur? _____

Is your dizziness brought on by certain head or body movements? _____

Do you feel dizzy or get dizzy:

Laying? _____ Rolling over in bed? _____ Standing? _____

Sitting? _____ Turning your head? _____ Looking up? _____

Standing up from sitting? _____ Standing up from laying? _____

Is the dizziness accompanied by any other symptoms, such as nausea, blurred vision, ringing or noise in the ear, decrease in hearing, headache, tingling or numbness in your arms or legs?

_____

Do you have difficulty:

Walking around your home with the lights out? _____

Standing in the shower? _____

Walking on uneven surfaces? _____

Reading or working at the computer? _____

Riding in the car as a passenger? _____

Is your dizziness getting better, worse or staying the same? _____

Are you afraid of falling? _____

Have you ever suffered a head injury or fell and hit your head? _____

Please describe your hearing: _____

Is you hearing equal or better in one ear? _____

Do you experience any ringing or other noises in one or both ears? _____

Did you notice any changes in your ears or hearing when the dizziness started? ☐ Yes ☐ No

I certify that the history form is filled out completely and accurately. I have answered all questions truthfully and to the best of my knowledge.

_____ _____

Patient Signature **Date**

I have reviewed the information of the two pages of the Dizziness Questionnaire with the patient.

_____ _____

Michael A. Freedman, D.O. **Date**