Houston Ear Nose and Throat Clinic LLP

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VESTIBULAR QUESTIONAIRE

I. When you are "dizzy" do you experience any of the following sensations? Please read the entire list first. Then circle YES or NO to describe your feelings most accurately.

YES	NO	1	Lightheadedness or swimming sensation in the head.
YES	NO	2	Blacking out or loss of consciousness.
YES	NO	3	Tendency to fall:
YES	NO		To the RIGHT?
YES	NO		To the LEFT?
YES	NO		FORWARD?
YES	NO		BACKWARD?
YES	NO	4	Objects spinning or turning around you.
YES	NO	5	Sensation that you are turning or spinning inside, with objects outside remaining stationary.
		6	Loss of balance when walking:
YES	NO		Veering to the RIGHT?
YES	NO		Veering to the LEFT?
YES	NO	7	Headache?
YES	NO	8	Vomiting?
YES	NO	9	Pressure in the head?

II Please Circle YES or NO and fill in the blank spaces. ANSWER ALL QUESTIONS.

		1	My dizziness is:
YES	NO		Constant?
YES	NO		In attacks?
		2	When did the dizziness first occur? _____
			If in attacks: How often? _____
			How long did they last? _____
			When was the last attack? _____
YES	NO		Do you have any warning that the attack is about to start?
YES	NO		Do they occur at any particular time of day or night?
YES	NO	3	Are you completely free of dizziness between attacks?
YES	NO	4	Does change of position make you dizzy?

(PLEASE GO TO NEXT PAGE.)

YES NO 5 Do you have trouble walking in the dark?

YES NO 6 When you are dizzy, must you support yourself when standing?

YES NO 7 Do you know of any possible cause of your dizziness? What? _____

_____

8 Do you know of anything that will:

YES NO Stop your dizziness or make it better? _____

YES NO Make your dizziness worse? _____

YES NO Precipitate an attack? (Fatigue, exertion, hunger, menstrual period, stress, emotional upset?) _____

YES NO 9 Were you exposed to irritating fumes, paints, etc., at the onset of dizziness?

10 If you are allergic to any medications, please list: _____

_____

YES NO 11 If you ever injured your head, were you unconscious?

YES NO 12 Do you take medications regularly, for any reasons, please list: _____

_____

YES NO 13 Do you use tobacco in any form? _____ How much? _____

III Do you have any of the following symptoms? Please circle YES or NO and circle what ear is involved.

YES	NO	1	Difficulty in hearing?	BOTH EARS	RIGHT	LEFT
YES	NO	2	Noise in your ears?	BOTH EARS	RIGHT	LEFT
			Describe the noise: _____			
YES	NO		Does the noise change with dizziness? If so, how? _____			
YES	NO	3	Fullness or stuffiness in your ears?	BOTH EARS	RIGHT	LEFT
YES	NO	4	Pain in your ears?	BOTH EARS	RIGHT	LEFT
YES	NO	5	Discharge from your ears?	BOTH EARS	RIGHT	LEFT

IV Have you ever experienced any of the following symptoms? Please circle YES or NO and circle if CONSTANT or IN EPISODES.

YES	NO	1	Double vision, blurred vision or blindness.	CONSTANT	IN EPISODES
YES	NO	2	Numbness of face?	CONSTANT	IN EPISODES
YES	NO	3	Numbness in arms or legs?	CONSTANT	IN EPISODES
YES	NO	4	Weakness in arms or legs?	CONSTANT	IN EPISODES
YES	NO	5	Clumsiness of arms and legs?	CONSTANT	IN EPISODES
YES	NO	6	Confusion or loss of consciousness?	CONSTANT	IN EPISODES
YES	NO	7	Difficulty with speech?	CONSTANT	IN EPISODES
YES	NO	8	Difficulty with swallowing?	CONSTANT	IN EPISODES
YES	NO	9	Pain in neck or shoulder?	CONSTANT	IN EPISODES