ROBERT T. SATALOFF, M.D., D.M.A., F.A.C.S.
KAREN M. LYONS, M.D.
ROBERT J. WOLFSON, M.D., F.A.C.S.
HELEN YOO BOWNE, M.D.
AMANDA HU, M.D.

Education/Research
Drexel University College of Medicine
American Institute for Voice and Ear Research

Clinical Care
Philadelphia, Ear, Nose & Throat Associates, L.L.C.

1721 Pine Street
Philadelphia, PA 19103
(215) 545-3322
Fax: (215) 790-1192

E-mail: Office@PhillyENT.com
www.PhillyENT.com

219 N. Broad Street, 10th Floor
Philadelphia, PA 19107
(215) 762-5530
Fax: (215) 762-5540

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

Otology/Neurotology • Occupational Hearing Loss • Laryngology/Professional Voice Care
Otolaryngology/Allergy • Facial Plastic/Cosmetic Surgery • Head and Neck Surgery

Drexel University College of Medicine does not provide clinical otolaryngologic patient care.

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