

Vertigo Questionnaire

1. When was your first episode of vertigo?	
2. Describe your symptoms (circle all that apply): spinning about to faint lightheaded nauseated seasick disequilibrium drunk can't describe other _____	
3. Length of episode:	
4. Describe your other episodes of vertigo -	
	Worst episode (date & symptoms):
	Most recent episode (date & symptoms):
	Duration of typical episode:
	Frequency:
5. Other symptoms associated with a typical episode (circle all that apply): nausea vomiting headache tinnitus - right / left / both hearing loss – right / left / both ear pressure – right / left / both ear pain – right / left / both vision changes speech changes chest pain excessive sweating extremity weakness or numbness mouth tingling fatigue other: _____	
6. What make it worse (circle all that apply): turning positional changes foods (salt) darkness stress hunger menstrual period it's spontaneous other: _____	
7. What makes the symptoms better?	
8. Prior Evaluation (date & recommendations):	
9. Current Medical Regimen:	
10. Medications tried and their effect:	
11. Describe your Ear History -	
	Any ear infections? no / yes dates: _____
	Any ear surgery? no / yes dates: _____
	Any head trauma? no / yes dates: _____
	Any history of tinnitus? no / yes dates: _____
	Exposure to ototoxins? (circle all that apply) caffeine aspirin quinine tobacco ethanol industrial fumes intravenous antibiotics – gentamicin / tobramycin
12. Any Whiplash Injury or Cervical Spine Disease? no / yes dates: _____	
13. Family History of Imbalance? no / yes family member(s): _____	

Name: _____

Date: _____