ASSOCIATED NEUROLOGICAL SPECIALTIES

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Dizzy Questionnaire- Long

This questionnaire will become a permanent part of the patient's medical record:

Name:_____ Age:_____ Today's Date:_____

Are you right-handed?_____ OR left-handed_____?

Present Occupation:_____

Prior Occupations:_____

_____

Education (Highest Level):_____

(Subject):_____

Name and Addresses of physician(s) or attorney(s) you wish our reports sent:

_____

_____

_____

_____

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY. PLEASE GIVE NECESSARY DETAILS FOR YES ANSWERS. There is additional room at the end of each section and the end of the questionnaire for comments. We realize this form is long, but when it is filled out carefully, it allows us to devote more time to your specific problem, rather than asking you unrelated questions during your visit.

1. Describe your major problem and the reason why you are seeing us:

2. Please describe in detail when and the circumstances in which the problem began and what were the initial symptoms and problems. What might have caused the problem to begin? Unusual exercise? Accident? Infection? Change in glasses? Change in type or dose of medications? Stress?

3. If you have dizzy spells, please describe a typical spell in as much DETAIL as possible and also describe the TRIGGERS, TIME OF OCCURRENCE, FREQUENCY, AND DURATION of the spells:

4. To what extent has your problem or spells changed since it first started? (For example: Severity, frequency, and characteristic)?

5. Please nark each symptom and give DETAILS for all “Yes” answers:

YES	NO	
____	____	Trouble with walking?
____	____	Trouble with balance?
____	____	Any falls?
____	____	Difficulty turning over in bed?
____	____	Sense of motion in the environment?
____	____	Sense of motion in one’s own body?
____	____	Sensation of one’s body tilting? (Which way?
____	____	Sensation of one’s body pulling? (Which way?)
____	____	Sensation of Rotation or spinning? (Which way?)
____	____	Sense of rocking?
____	____	Spinning inside of one’s head?
____	____	Sense of walking on pillows?
____	____	Lightheadedness or faintness?
____	____	Fear of avoidance of public places?
____	____	Sweating?
____	____	Nausea?
____	____	Vomiting?
____	____	Impaired Vision?
____	____	-Double Vision?
____	____	-Images separated side-to-side, up and down, or tilted?
____	____	-Blurred vision?
____	____	-Flashes of light?
____	____	-Jumping of vision?
____	____	-Trouble Reading?
____	____	Dry eyes?
____	____	Dry mouth?
____	____	Trouble with taste?
____	____	Trouble with smell?

6. What do you think your problem is due to?

7. What have you been told your problem is due to?

8. TO WHAT EXTENT IS YOUR DIZZINESS OR IMBALANCE AFFECTED OR BROUGHT ON BY:

SEVERELY	MODERATELY	NOT AT ALL	
_____	_____	_____	Turning over in bed?
_____	_____	_____	Bending over, looking up?
_____	_____	_____	Standing up quickly?
_____	_____	_____	Rapid head movements?
_____	_____	_____	Walking in the dark?
_____	_____	_____	Elevators, escalators, or stairs?
_____	_____	_____	Airplane, boat, or car travel?
_____	_____	_____	Scuba diving?
_____	_____	_____	Loud noises?
_____	_____	_____	Cough, sneeze, strain, or laugh
_____	_____	_____	Moving Objects (eg. Computer screens, lights, windshield wipers, TV or movies)?
_____	_____	_____	Moving your eyes with your head still?
_____	_____	_____	Are you dizzy with your eyes closed?
_____	_____	_____	Touching your ears?
_____	_____	_____	Wide-open or narrow spaces (eg. Shopping malls, supermarket)?
_____	_____	_____	Tunnels, bridges, or heights
_____	_____	_____	Thinking about or anticipating going to a specific place
_____	_____	_____	Exercise (Aerobics, jogging)
_____	_____	_____	Other activities? (What)?
_____	_____	_____	Eating or missing meals?
_____	_____	_____	Special foods (salt, MSG, cheese, wine, chocolate, alcohol, caffeine)?
_____	_____	_____	Heat, hot showers or baths, or cold?
_____	_____	_____	Time of day?
_____	_____	_____	Swallowing?
_____	_____	_____	Depression, anxiety, nerves, or stress
_____	_____	_____	Menstrual periods?

DETAILS:

9. Other questions concerning dizziness:

YES	NO	
____	___	Can you bring on your dizziness voluntarily?
		(IF YES, PLEASE GIVE DETAILS)
____	___	Do or did you have moderate to severe motion sickness?
		(CAR OR BOAT, PLEASE DESCRIBE)
____	___	Do you ice skate; do gymnastics, or high intensity aerobics?
____	___	Has anyone observed jerking of your eyes with dizzy spells?
____	___	Have you had a caloric (air or water in the ear) test?
____	___	Was the sensation induced similar to your own dizziness?
____	___	Does your dizziness resemble the sensation provoked by spinning oneself round and round and then stopping?

10. HAVE YOU EVER HAD: (IF YES, PLEASE GIVE DETAILS)

YES	NO	
____	___	Infections of the ears?
____	___	Sinus disease?
____	___	Inner ear disease (eg. LABYRINTHITIS)?
____	___	Difficulty with hearing? (WHICH EAR?)
____	___	Pain, fullness, popping, or pressure in the ear? (WHICH EAR?)
____	___	Ringing in the ears? (TINNUTIS)
		Which ear? _____ Steady or pulsating? _____
		High or low pitched?
		State the frequency and duration of the tinnitus:
____	___	Pain, pins & needles, numbness, twitching, or weakness of face?
____	___	Crossed eyes or lazy eye?
____	___	Do you wear glasses? (FOR READING, FAR VIEWING, OR BOTH)
____	___	Are you very nearsighted?

11. Have you had migraine or other headaches?

A. If yes, please answer the following:

Approximate age they began: _____

Frequency of headaches in last 6 months:

Pain intensity (1 to 10, with 10 the most severe):_____

B. If yes, does your headache usually:

YES	NO	
____	___	Last 4 hours or more
____	___	Start on one side of the head? Which side?_____
____	___	Throbbing or pulsatile in quality?
____	___	Severe enough to interfere with your schedule?
____	___	Related to diet or menstrual periods?
____	___	Aggravated by routine physical exercise?
____	___	Made worse by climbing stairs?
____	___	Brought on by cough, sneeze, or strain?
____	___	Associated with nausea and/or vomiting?
____	___	Aggravated by bright lights or loud noises?
____	___	Preceded by bright or flashing lights or zigzag lines?
____	___	Usually relieved by dark rooms and/ or sleep?
____	___	Require medications? (Which medications and how often?)

____ ___ **Do you take medication more than 2 times per week?**

12. CIRCLE AND GIVE DETAILS OF SYMPTOMS YOU HAVE HAD IN THE LAST FEW YEARS:

-Weight change (Gain or loss, how much, & over what period)

-Strength or Energy Change	-Appetite Change	-Muscle Aches
-Memory Loss (Amnesia)	-Change in Handwriting	-Joint Aches
-Skin Rash or Birthmarks	-Sore in Mouth or Genitals	-Diarrhea
-Numbness in Arms or Legs	-Lump in Throat	-Heart Palpitations
-Loss of Bowel Control	-Fever or Chills	-Swollen Glands
-Loss of Bladder Control	-Problems with Sleeping	-Incoordination
-Problems with Sexual Function	-Abnormal Menstrual Periods	-Shortness of Breath
-Excessive Daytime Sleepiness or Naps	-Sweating	-Change in Speech
-Trouble Chewing, Swallowing	-Tremor or Shakiness	-Stiffness
- Snoring or Sleep Apnea		

13. HAVE HAD ANY INJURIES? (IF YES, PLEASE EXPLAIN)

YES	NO	
____	___	Ears?
____	___	Eyes?
____	___	Retinal Detachment?
____	___	Head?
____	___	Have you seen a Chiropractor? When?
____	___	Miscarriages?
____	___	Other Injuries?

14. HAVE YOU HAD ANY SURGERY? (IF YES, DESCRIBE THE SURGERY AND WHEN IT OCCURRED)

YES	NO	
____	___	Ears?
____	___	Eyes?
____	___	Head?
____	___	Neck?
____	___	Other?

15. HAVE YOU BEEN EXPOSED TO OR EXPERIENCED ANY OF THE FOLLOWING? (IF YES, PLEASE DESCRIBE THE EXPOSURE AND WHEN IT OCCURRED).

YES	NO	
____	___	Poisons, gases, chemicals, or carbon monoxide?
____	___	Tropical Diseases?
____	___	Tick Bites?
____	___	Intravenous Antibiotics?
____	___	Military Service overseas? (Where?)
____	___	Travel to central or South America, Asia, Africa?
____	___	AIDS?
____	___	Blood Transfusions?
____	___	Loud Noise? (eg. Guns, Machinery, Loud Music?)
____	___	Drug Therapy for cancer? (eg. Chemotherapy) (What type?)
____	___	Medication for depression, anxiety, or other psychiatric disease? (Lithium, Valium, Dilantin, Tegretol, sleeping pills, Ativan, Xanax, Phenothiazine, OR any other tranquilizers?) (what type and when?)

16. HAVE YOU HAD ANY OF THE FOLLOWING INFECTIONS? (IF YES, PLEASE GIVE DETAILS)

YES	NO	
____	___	Syphilis or other sexually transmitted disease?
____	___	Mononucleosis (Epstein-Barr)?
____	___	Lyme Disease?
____	___	Meningitis?
____	___	Other Infections?

17. HAS YOUR PAST OR PRESENT HEALTH BEEN AFFECTED BY:

YES	NO	
____	___	Heart Problems?
____	___	Diabetes?
____	___	Low sugar (hypoglycemia)?
____	___	Thyroid Disorders?
____	___	Treatment by a psychiatrist or counselor?
____	___	Depression; thought of harming yourself; feeling of worthlessness; crying spells?
____	___	Stress?
____	___	Eating disorders or phobias?
____	___	Anxiety or panic attacks?
____	___	High cholesterol (triglycerides)?
____	___	High or low blood pressure?
____	___	Pain in back of jaw (TMJ), grinding?
____	___	Loss of consciousness (fainting), seizures, or convulsions?
____	___	Blood diseases, anemia?
____	___	Skin diseases?

18. List all major illnesses, injuries, surgeries, or miscarriages not described above.

19. What are your current medications? (Include all medications, hormones, birth control pills, over-the-counter medications, vitamins, herbal medications, and other alternative therapies and AMOUNT/ DAY:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

20. What other medications have you taken for your dizziness? (Include dosage, for how long, and effectiveness):

_____	_____
_____	_____
_____	_____

21. List all known allergies, including those to medications or bad reactions to medicines.

22. Social History:

YES	NO	
____	___	Do or did you use alcohol? How much? How does alcohol affect your condition?
____	___	Do or did you ever smoke? If so, please answer the following: a. How many packs/ day? _____ b. What age did you start? _____ c. If you quit, at what age? _____
____	___	Do or did you ever use drugs? LSD?____ Cocaine?____ Crack? ____ Marijuana? ____ Other?_____
____	___	Do you use salt to eat salty foods?
____	___	Do you have an unusual diet? Vegetarian?
____	___	Do you have pets? If so, what kind and how many?
____	___	What are your hobbies?

23. Personality

a. Would you describe yourself as any of the following:

Obsessive	Manic	Compulsive
Down or Depressed	Prone to Anxiety	Melancholy or Blue
Hypochondriac	Phobic	

b. Do you set your watch ahead?_____ How much?_____

24. Family History

a. Do you have children? _____ If so, what are their ages? Their health condition?

b. Do you have brothers or sisters? _____ If so, what are their ages? Their health conditions?

c. Do you have any family members with the following (Please indicate which family member; include also grandparents, aunts, uncles, nieces, nephews, and cousins):

YES	NO	
____	___	The same condition as you have?
____	___	Migraine Headaches?
____	___	Meniere's Syndrome?
____	___	Hearing Loss?
____	___	Vertigo or Dizziness?
____	___	Balance Problems?
____	___	Tremor?
____	___	Convulsions or seizures?
____	___	Diabetes?
____	___	Cancer?
____	___	Kidney Problems?
____	___	Brain Tumors?
____	___	Stroke?
____	___	Heart Disease?
____	___	High Blood Pressure?
____	___	Psychiatric Disorders, Depression, or Panic Attacks?
____	___	Memory Problems, Dementia, or Alzheimer's?
____	___	Other Neurological Diseases?
____	___	Any other conditions that run in the family?
____	___	Mental Retardation?

d. If your parents, brothers, sisters, or any children have died, at what age and from what cause?

25. Have you had the following:

YES	NO		WHO/ RESULT	WHEN
____	___	Hearing Test?		
____	___	Evaluation by another neurologist?		
____	___	Evaluation by an ear doctor?		
____	___	Caloric Test? (Water or air in ear)		
____	___	MRI?		
		(If so, was contrast given by injection?)		
____	___	Brain Arteriorgram?		
____	___	Carotid Artery Blood Flow Supply?		
____	___	BAER? (Auditory Evoked Potentials)		
____	___	VER? (Visual Evoked Potentials)		
____	___	Sinus X-rays?		
____	___	Neck X-rays?		
____	___	MRI of Neck or Spine?		
____	___	CT Scan of head, neck, or spine?		
____	___	Spinal Fluid Examination?		
____	___	EEG (Brain Wave Study)?		
____	___	EMG/ Nerve Conduction Study?		

26. Have you recently had the following:

YES	NO		WHO/ RESULT	WHEN
____	___	Blood Work?		
____	___	Urinalysis?		
____	___	Chest X-Ray?		
____	___	Mamograms?		
____	___	GYN (Pelvic) exam?		
____	___	Echocardiogram?		
____	___	ENG?		
____	___	Lyme Test?		
____	___	Glucose Tolerance Test?		
____	___	B12 Test?		
____	___	Thyroid test?		
____	___	AIDS test?		

27. Handwriting specimen: Please write the following: "Whether or not you leave here early does not matter."

_____

_____

28. Additional Comments: