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

Robert T. Sataloff, M.D., D.M.A.
Karen M. Lyons, M.D.
Stephen A Goldstein, M.D.
Yolanda Heman-Ackah, M.D.

Pepper Pavilion, Suite 608
Philadelphia, PA 19146
(215) 893-6640
FAX (215) 893-2460

PATIENT HISTORY:DIZZINESS

NAME:____ AGE: _____________ DATE:

1. WHEN DID YOU FIRST DEVELOP DIZZINESS?

2. WHAT IS IT LIKE? (PLEASE CHECK ALL THAT APPLY)

_____a. Light headedness
_____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

4. IF EPISODIC, HOW LONG DO THE ATTACKS LAST? ____
How often do you have the attacks? ____
Have they been more/ess 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? Describe briefly:

PLEASE CHECK ALL THAT APPLY.

7.____COMPLETELY FREE OF DIZZINESS BETWEEN ATTACKS

8.___ DIZZINESS ROLLING OVER IN BED

To right ____ To left_____

9. _____DIZZINESS WITH CHANGE OF POSITION.

What kind of position change?

10. ____DIZZINESS ONLY OCCURRING IN CERTAIN POSITIONS. If so please indicate:

_____Upright _____Turning to right

_____Lying flat _____Turning to left

11.___ DIZZINESS FROM

_____Bending

_____Lifting

_____Forceful nose blowing

12._____TROUBLE WALKING IN THE DARK.

13._____ KNOW OF ANY POSSIBLE CAUSE OF YOUR DIZZINESS.

If so, please describe:

14._____ANYTHING THAT WILL STOP YOUR DIZZINESS OR MAKE IT BETTER.

If so, please describe:

15._____ANYTHING THAT WILL BRING ON AN ATTACK OR MAKE YOUR DIZZINESS WORSE.

_____Fatigue _____Certain foods

_____Exertion _____Menstrual

_____Hunger _____Other

16.___ ANY WARNING SIGN THAT AN ATTACK IS ABOUT TO START.

_____Yes _____No

17. ___ONCE AN ATTACK HAS BEGUN, DOES HEAD MOVEMENT MAKE IT WORSE?

___Yes ___No

18. ___SIGNIFICANT DIFFICULTY WITH MOTION SICKNESS NOW OR IN THE PAST.

19. _____HEADACHES IN RELATION TO THE ATTACK.

20. _____MIGRAINE HEADACHES

21. _____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
_____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
_____Have you ever injured your head?
_____Unconscious _____Bleeding from Ear
_____Hit directly in ear R L Both
_____Have you every 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