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VNG QUESTIONNAIRE

PLEASE BRING THIS FORM COMPLETED TO THE APPPOINTMENT

Name: _____ **Date:** _____
Follow-up date with ENT: _____

Please indicate which of the following "dizziness" symptoms you have experienced:
_____Lightheadedness or a swimming sensation in the head.
_____Presyncope (feeling faint) or fainting (blacking out or loss of consciousness)
_____Imbalance when walking in the light or dark
_____Tendency to veer to the right or left when walking
_____Unable to stand unsupported
_____Tendency to fall
_____Vertigo (spinning)
_____Objects spinning or turning around you
_____Sensation that you are spinning with outside objects remaining stationary

When did your dizziness first occur? _____
Any events prior to the onset of dizziness (illness, trauma, etc.)?_____
Is the dizziness constant or does it come in attacks?_____
Please answer the following questions If your dizziness occurs in attacks:
How frequently do they occur?_____
How long does it last?_____
Do attacks occur more frequently in the morning, day, or evening?_____
Do they come on gradually or suddenly?_____
Do you have any warning sign that an attack is imminent?_____
Are you completely free of dizziness between attacks?_____

Please check and explain any symptoms that you may be experiencing:
_____ Nausea
_____ Vomiting
_____ Hearing loss (both ears, right ear, or left ear)
Does your hearing change with the dizziness? Yes or No
_____ Tinnitus
Describe the tinnitus:_____
Does the tinnitus change with the dizziness? Yes or No (circle one)
_____ Aural fullness or stuffiness in your ears (both ears, right ear, left ear)
_____ Pain in the ears (both ears, right ear, left ear)
_____ Discharge or drainage from the ears (both ears, right ear, or left ear)
_____ Headaches
_____ Pressure in the head

_____ Pain in the neck or shoulders
_____ Neck mobility issues
_____ Severe back issues
_____ Tingling in the fingers or toes
_____ Tingling around the mouth
_____ Double vision
_____ Blurred vision
_____ Blindness
_____ Numbness of the face or extremities
_____ Weakness in the arms or legs
_____ Confusion or loss of consciousness
_____ Difficulty with speech
_____ Difficulty with swallowing

Please explain if symptoms are provoked with any of the following:
Does a change in body position trigger the dizziness? _____
Does a change in head position trigger the dizziness? _____
Do you become dizzy when you bend your head forward or backward? _____
Do you become dizzy when you roll over in bed to the right or left? _____
Do you become dizzy when you cough? Sneeze? Or during a bowel movement? _____
Do you know of any possible causes for your dizziness? _____
Does anything make your dizziness better? _____
Do loud sounds trigger your dizziness? _____
Do bright lights cause you to feel light-headed or dizzy? _____

Please mark if any of the following make your dizziness worse:

_____ Fatigue
_____ Exertion
_____ Hunger
_____ Menstrual period
_____ Stress
_____ Emotional upset
_____ Alcohol
_____ Caffeine
_____ Allergies

Medical History
History of earaches or ear infections as a child? _____
History of ear surgeries? _____
Have you ever injured your head? When? _____
Were you ever unconscious? When? _____
Have you ever suffered from motion sickness? _____
Have you ever taken medication for your dizziness? _____
Is there a family history of dizziness? _____
Is there a family history of ear disease, neurological disease, or migraines? _____
Do you have any of the following medical conditions:

_____ Diabetes
_____ Heart disease

_____ High blood pressure
_____ Thyroid disease
_____ Migraines
_____ Cancer

Current Medications – Please list all prescriptions, over the counter medicines, and nutritional supplements (herbal, vitamin, or dietary) that you are currently taking. If you have a list already, please provide to the receptionist and we will make a copy for our records.

Name of Medication	Dosage & Frequency	Route of Adminstration (oral, IV, etc.)

Dizziness Handicap Inventory

Instructions: The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your dizziness. Please answer every question. Please do not skip any questions.

Dizziness Handicap Inventory (DHI)				
Question	*Yes (4)*	*Sometimes (2)*	*No (0)*	*Aspect*
Does looking up worsen your problem?				Physical
Do you feel frustrated because of your problem?				Emotional
Do you limit your business or leisure travels because of your problem?				Functional
Does walking in a supermarket worsen your problem?				Physical
Do you find it difficult to lay down or get up from bed?				Functional
Does your problem restrict your participation in social activities?				Functional
Do you find it hard to read because of your problem?				Functional
Does your problem worsen with physical activities (dancing, housework, etc.)?				Physical
Because of your problem, do you feel afraid to go out unaccompanied?				Emotional
Because of your problem, do you feel embarassed around other people?				Emotional
Do quick movements of your head worsen your problem?				Physical
Due to your problem do you avoid high places?				Functional
Does turning over in bed worsen your problem?				Physical
Because of your problem, is it difficult to complete household tasks?				Functional
Because of your problem, do you fear that people think you are drunk or drugged?				Emotional
Because of your problem, is it difficult to walk without assistance?				Functional
Does walking on the sidewalk worsen your problem?				Physical
Because of your problem, is it difficult to concentrate?				Functional
Because of your problem, is it difficult to walk in your house in the dark?				Physical
Due to your problem, do you fear being home alone?				Emotional
Due to your problem, do you feel you are disabled?				Emotional
Does your problem damage your relationship with family and friends?				Emotional
Due to your problem, are you depressed?				Emotional
Does your problem interfere with your work or household duties?				Functional
Does becoming inclined worsen your problem?				Physical

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Subscale	*Points*
Physical	
Emotional	
Functional	
Total	