Finn R. Amble, MD, FACS, SC
Eastland Medical Plaza I
1505 Eastland Drive, Suite 220
Bloomington, IL 61701
Phone: 309-585-0370 • Fax: 309-663-2956

Dear Patient,

Thank you for choosing Finn R. Amble, MD, FACS/Central Illinois Hearing and Balance Center. We understand the detrimental effect dizziness can have on your daily activities and we are here to help. By receiving and completing this survey you are taking the first step in the evaluation process. Dizziness is a very complicated medical issue which can be caused by a variety of medical problems. The professionals at the Central Illinois Hearing and Balance Center use a multidisciplinary approach to ensure the best care possible in diagnosing and treating your dizziness. Treatment may involve several diagnostic procedures and office visit with multiple professionals.

Please take the time to complete this survey and return it to the office. Once the survey is received, the Audiologist will review the survey and contact you to set up the appropriate appointment and/or therapy.

Sincerely,

Joanna Capobianco, AuD., CCC-A

Courtney Parmley, AuD., CCC-A

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Dizziness Questionnaire

Date:

Name: DOB:

Address:

Phone Number:

Height/Weight:

Referring Physician:

Currently, my dizziness…
____is constant.
____is always there, but changes in intensity.
____come and goes.
If comes and goes:
How long does it typically last? _____seconds / minutes / hours (Circle ONE)
How often does it typically occur? _____times per: hour / day / week / month / year

My dizziness mostly consists of… (Check ALL that apply)
____spells of spinning with nausea.
____off-balance sensation without dizziness.
____a light-headed or near faint sensation.
____other. Please explain:

Between episodes I feel… (Check ONE)
____dizzy or off balance all the time.
____normal.
____other. Please explain:

My episodes occur… (Check ALL that apply)
____spontaneously. Nothing I do seems to bring them on or turn them off.
____only when standing or walking.
____in relation to any head motion.
____in relation to only certain head positions. Please describe:

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When I roll over in bed... (Check ONE)
____nothing unusual happens.
____the room seems to spin sometimes.
____the room spins every time.

Is there anything that you can do to make the dizziness go away? (sit, lay down, close eyes...)
Please explain:

Circle all that apply:
I have hearing difficulty..Right.....Left.....Both
I have ringing or other sounds.................................Right.....Left.....Both
I have fullness...Right.....Left.....Both
I have had ear surgery...Right.....Left.....Both
Please Explain:
I have drainage from my ears..................................Right.....Left.....Both

Circle YES or NO

YES NO Did you have cold, flu, or virus type symptoms shortly before the onset of your dizziness?

YES NO Does your hearing change during your dizziness?

YES NO If you had head trauma prior to your dizziness?

YES NO Do you get dizzy when you have not eaten in a long time?

YES NO I consider myself to be an anxious or tense person.

YES NO I am under a great deal of stress.

YES NO I have had eye surgery in the past and/or significant vision difficulties
If yes, please explain:

In the past year I have had... (Check ALL that apply)
____loss of consciousness
____seizures or convulsions
____slurring of speech
____difficulty swallowing
____weakness in one hand, arm, or leg
____double vision
____occasional loss of vision
____severe pounding headache or migraine
____palpitation of the heartbeat
____tingling around mouth
____tendency to fall
____loss of balance when walking

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I have or have had… (Check ALL that apply)

____Diabetes	____Stroke
____High Blood Pressure	____Fibromyalgia
____Low Blood Pressure	____Migraine Headaches
____Arthritis	____Neck and/or back injury
____Irregular Heartbeat	____Allergies
____Depression	____Anxiety
____ Other:	

Please List Current Medications:

Do you drink coffee, tea or soda? If so, how much/often?

Do you drink alcohol? If so, how much/often?

Do you smoke? If so, how much/often?

Do you have mobility issues (back problems, neck problems, walking unassisted?) Please specify:

Have you ever been previously evaluated for dizziness? If yes, when and where? What were the findings?

Do you have any other information concerning your problem that we have not asked about?

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Please have this questionnaire mailed or forwarded to:

Finn R. Amble, MD, FACS, SC

1505 Eastland Drive, Suite 220

Bloomington, IL 61701

Attn: Audiology

309-663-2956 (fax) Attn: Audiology

Thank you for taking the time to complete this survey. Once it is received we will review the survey and contact you to arrange the appropriate appointment if it is not already scheduled.

Sincerely,

Joanna Capobianco, AuD., CCC-A
Courtney Parmley, AuD., CCC-A