CHOP Dizziness Questionnaire

Please describe the dizzy or balance symptoms in detail:

When did symptoms start?

How long do symptoms last?

☐ seconds ☐ minutes ☐ hours ☐ days

How often do symptoms occur?

☐ constant ☐ daily ☐ weekly ☐ monthly ☐ yearly

Associated symptoms- please check all symptoms that apply:

- light headedness ☐
- nausea/vomiting ☐
- ear fullness/pressure ☐
- ringing in the ears ☐
- ear pain ☐
- decreased hearing ☐
- headache ☐
- blurred or double vision ☐
- vision loss ☐
- unusual eye movements ☐
- fainting spells or passing out ☐
- frequent falls ☐
- loss of balance ☐
- cold or flu symptoms ☐
- weakness or numbness in arms/leg ☐
- palpitations (rapid or fluttering heartbeat) ☐
- chest pain ☐
- loss of consciousness ☐
- light sensitivity ☐
- noise sensitivity ☐
- smell sensitivity ☐
- slurred speech ☐
- confusion ☐
- head tilt ☐

Are the symptoms triggered by- please check all that apply:

- lying down or rolling over ☐
- head movement ☐
- sitting or standing up ☐
- loud noise ☐
- exercise ☐
- coughing, sneezing, straining ☐
- stress ☐
- headaches ☐
- flying, traveling by car or boat ☐
- certain foods ☐
- menstrual cycle ☐

Patient Medical History- please check all that apply:

- seizures ☐
- head trauma ☐
- hearing loss ☐
- anxiety ☐
- concussion ☐
- torticollis ☐
- heart disease ☐
- developmental delays ☐
- migraines ☐
- motion sickness ☐
- frequent ear infections ☐
- perforated eardrum (hole in eardrum) ☐
- high blood pressure ☐
- diabetes ☐
- eye disease ☐
- cancer ☐
- thyroid disease ☐
- meningitis ☐
- chiari malformation ☐

Patient Surgical History- Please check all that apply:

- ear tubes ☐
- cochlear implant ☐
- cholesteatoma ☐
- tympanoplasty (patch of a hole in eardrum) ☐
- Other, please list

Birth History

Full Term Delivery	☐ YES	☐ NO- BORN at _____ WEEKS
Pass newborn hearing screen	☐ YES	☐ NO
Treatment for jaundice	☐ YES	☐ NO
NICU stay (neonatal intensive care unit)	☐ YES	☐ NO
length of NICU stay		

Prior Testing- Please check all that apply:

- MRI head/neck/internal auditory canal ☐
- CT scan of head/neck/temporal bone ☐
- Audiogram ☐

Prior Treatment- Please check all that apply:

- Medications- meclizine or antivert ☐
- Physical Therapy ☐
- Other, please list

Current Medications- Please list:

Allergies to Medications - Please list:

Prior Medications- please check all that apply:

- gentamicin - antibiotic medication ☐
- tobramycin -antibiotic medication ☐
- vancomycin - antibiotic medication ☐

furosemide (lasix) ☐
high dose aspirin ☐
cisplatin- cancer medication ☐

Family History- please check all that apply:

Migraines ☐
Hearing loss at a young age ☐
Thyroid Disease ☐
Meniere's Disease ☐
Seizures ☐

Education History

School/grade ____________

Special Services- please check all that apply:

Hearing support ☐
Speech Therapy ☐
Special Education ☐
Occupational Therapy ☐
Physical Therapy ☐
Behavioral Support ☐