Tampa Bay ENT

Adult and Pediatric Ear, Nose and Throat • Facial Plastic Surgery

Name ____________________ Date____________________

Dizziness Evaluation
Instructions

1. Please do not take medications listed below for 48 hours prior to your test date. Certain medications can influence the body's response to the test, thus giving false or misleading results.
   a. Alcohol: beer, wine, cough medicine
   b. Analgesics-Narcotics: Codeine, Demerol, Phenaphen, Tylenol, with codeine, Percocet, Darvocet
   c. Anti-histamines: Chlor-trimeton, Dimetapp, Disophrol, Benadryl, Actifed, Teldrin, Hismanol, Claritin…any over the counter cold remedies
   d. Anti-Seizure medicine; Dilantin, Tegretol, Phenobarbital
   e. Anti-vertigo medicine: Anti-vert, Ru-vert, Meclizine
   f. Anti-nausea medicine: Atrax, Dramamine, Compazine, Anti-vert, Bucladin, Phenergan, Thorazine, Scopalomine, Transdermal
   g. Sedatives: Halcion, Restoril, Nembutal, Seconal, Dalmane, or any sleeping pill
   h. Tranquilizers: Valium, Librium, Atarax, Vistaril, Serax, Ativan, Librax, Xanex
   i. You may take blood pressure medications, heart medications, thyroid medications, Tylenol, insulin, estrogen, etc.
   j. Always consult with your physician before discontinuing any prescribed medication
2. Please eat lightly 12 hours prior to your appointment. If your appointment is in the morning you may have a light breakfast such as toast and juice.
3. Please avoid caffeine in beverages such as coffee or soft drinks.
4. **Please do not wear eye makeup.**
5. Testing may cause a sensation of motion that may linger. If possible we encourage you to have someone accompany you to and from the appointment. However, if this in not possible try to plan your day to include an extra 15 to 30 minutes after your test before leaving the office.

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Name ___________________________________ Date___________________________________

Dizziness Questionnaire

1. When did the dizziness first occur? (please describe in detail)

____

2. When dizzy do you experience any of the following? (please mark yes or no)
   a. Light headedness ☐ YES ☐ NO
   b. Swimming sensation in the head ☐ YES ☐ NO
   c. Objects spinning around you ☐ YES ☐ NO
   d. Sensation that you are spinning with outside objects remaining constant ☐ YES ☐ NO
   e. Tendency to fall (which way)_______ ☐ YES ☐ NO
   f. Loss of balance when walking ☐ YES ☐ NO
      ☐ RIGHT ☐ LEFT
   g. Blacking out ☐ YES ☐ NO
   h. Headache ☐ YES ☐ NO
   i. Loss of consciousness ☐ YES ☐ NO
   j. Nausea or vomiting ☐ YES ☐ NO
   k. Pressure in the head ☐ YES ☐ NO

3. Mark Yes or No and please describe if indicated
   a. My dizziness is constant ☐ ,in attacks ☐
   b. If dizziness occurs in attacks how often do they occur___________, how long do they last____________?
   c. When was your last attack? ________________________________
   d. Does your dizziness seem to be getting ☐ better or ☐ worse?
   e. Can you tell when the attack is about to start? ☐ YES ☐ NO
      i. Describe____
   f. Does change of position make you dizzy? ☐ YES ☐ NO
   g. Do you know of anything that will:
      i. Make dizziness better?___________________________ ☐ YES ☐ NO
      ii. Make dizziness worse?___________________________ ☐ YES ☐ NO
      iii. Precipitate an attack?___________________________ ☐ YES ☐ NO

4. Mark Yes or No
   a. Difficulty hearing? ☐ RIGHT ☐ LEFT ☐ BOTH
   b. Noise in ears? ☐ RIGHT ☐ LEFT ☐ BOTH
      i. Please describe____
   c. Fullness in ears? ☐ RIGHT ☐ LEFT ☐ BOTH
   d. When did you first notice your hearing loss?____

5. Do you experience the following?
   a. Double Vision? ☐ YES ☐ NO ☐ CONSTANT ☐ EPISODES
   b. Blurred Vision? ☐ YES ☐ NO ☐ CONSTANT ☐ EPISODES
   c. Difficulty with speech? ☐ YES ☐ NO ☐ CONSTANT ☐ EPISODES
   d. Numbness of extremities? ☐ YES ☐ NO ☐ CONSTANT ☐ EPISODES

6. Please list the medications you are currently taking

____

____

____

7. Do you smoke? ☐ YES ☐ NO If yes, how much? ____________________________

8. Do you have a tendency to have motion sickness? ☐ YES ☐ NO