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**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**I)** When you are “dizzy” do you experience any of the following sensations? Please read the entire list first. The circle YES or NO to describe your feelings most accurately.

YES NO 1. Lightheadedness or swimming sensation in the head?

YES NO 2. Blacking out or loss of consciousness?

YES NO 3. Tendency to fall: To the right?

YES NO To the left?

YES NO Forward?

YES NO Backward?

YES NO 4. Objects spinning or turning around you?

YES NO 5. Sensation that you are turning or spinning inside, with outside objects remaining stationary?

YES NO 6. Loss of balance when walking: Veering to the right?

YES NO Veering to the left?

YES NO 7. Headache?

YES NO 8. Nausea or Vomiting?

YES NO 9. Pressure in the head?

**II)** Please circle YES or NO and fill in the blank spaces. Answer all questions.

1) My dizziness is:

YES NO Constant?

YES NO In attacks?

2. When did the dizziness first occur?

3. If in attacks: i. How often?  
ii. How long do they last?  
iii. When was the last attack?

YES NO iv. Do you have any warning that the attack is about to start?

YES NO v. Do they occur at any particular time of the day or night?

**OVER...**

YES NO vi. Are you completely free of dizziness between attacks?

YES NO 4. Does change of position make you dizzy?

YES NO 5. Do you have trouble walking in the dark?

YES NO 6. When you are dizzy, must you support yourself when standing?

YES NO 7. Do you know of any possible cause for your dizziness? What?

8. Do you know of anything that will:  
Stop your dizziness or make it better?  
Make your dizziness worse?  
Precipitate an attack?  
(Fatigue? Exertion? Hunger? Menstrual Cycle? Stress? Emotional Upset?)

YES NO 9. Were you exposed to any irritating fumes, paints, etc. at the onset of dizziness?

YES NO 10. If you ever injured your head, were you unconscious?

**III)** Do you have any of the following symptoms? Please circle YES or NO and circle ear involved.

YES NO 1. Difficulty hearing? Both Right Left

YES NO 2. Noise in your ears? Both Right Left

Describe the noise

YES NO Does the noise change with dizziness? If so, how?

YES NO 3. Fullness or stuffiness in your ears? Both Right Left

YES NO 4. Pain in your ears? Both Right Left

YES NO 5. Discharge from your ears? Both Right Left

**IV)** Have you experienced any of the following symptoms? Please circle YES or NO and circle if constant or in episodes.

YES NO 1. Double vision, blurred vision or blindness? Constant Episodes

YES NO 2. Numbness of face? Constant Episodes

YES NO 3. Numbness of arms or legs? Constant Episodes

YES NO 4. Weakness in arms or legs? Constant Episodes

YES NO 5. Clumsiness of arms or legs? Constant Episodes

YES NO 6. Confusion or loss of consciousness? Constant Episodes

YES NO 7. Difficulty with speech? Constant Episodes

YES NO 8. Difficulty with swallowing? Constant Episodes

YES NO 9. Pain in the neck or shoulder? Constant Episodes