Ordering Physician
Todd Berinstein, MD
David Bloom, MD

VERTIGO (Dizziness)

Name: _____ Date: _____

We are interested in your illness and would like to find out more. Please fill this out to the best of your knowledge. If you do not know the exact dates and duration, please estimate.

1. Do you have seasonal or food allergies?
   □No □Yes If yes, please list:_____
2. Please write the **first date** you experienced dizziness: _____
3. What did it feel like the first time you were dizzy? **Circle all that apply:**

   Nausea Vomiting Ringing in the Ear(s) Headache Spinning
   Passing out Light Headed Clouded Thoughts Head Fullness Ear Fullness
4. How long did the first episode last? (1 min, 10 min, 1 hour, 1 day, 1 week)
   _____
5. Was there any hearing change during the first episode or afterwards?
   □No □Yes If yes, how did it change?_____
   _____
6. Please circle how often/ frequently you are experiencing dizziness **NOW:**

   Daily Weekly Every Month Every 6 Months Every Year
7. What is happening to your dizziness? (**circle one**)

   It is the same It is improving It is worsening
8. Are you able to tell when dizziness is about to happen (are there warning signs)?
   □No □Yes If yes, what is the sign? _____
9. Have you ever had ear surgery?
   □No □Yes If yes, what kind? _____
10. Have you ever had ear infections?
    □No □Yes If yes, when? _____
11. Have you ever had any problems with your eyes?
    □No □Yes If yes, what kind? _____
12. Have you been diagnosed with migraines?
    □No □Yes If yes, what kind? _____
13. Have you had any scans (images) of your brain?
    □No □Yes If yes, what kind? _____