HISTORY & PHYSICAL FOR DIZZINESS

Name_____ Age_____

Date:_____Consultation Requested by Dr._____

Address_____

Brief History_____

_____

Onset_____Frequency_____

DURATION OF SPELLS: seconds minutes hours days constant

SYMPTOMS:

nausea	vomiting	room spinning
falling	staggering (right/left)	cold sweats
passing out	constant/intermittent	light-headed

POSITIONAL CORRELATION:

lying flat	turning in bed (right/left)
fast movement	looking up/down

	Right	Left	AU	Fluctuating	Steady	Duration
Hearing Loss:	☐	☐	☐	☐	☐	_____
Tinnitus:	☐	☐	☐	☐	☐	_____
Fullness:	☐	☐	☐	☐	☐	_____

Previous Testing & X-rays:_____

Previous Diagnosis:_____

Previous Treatment for Dizziness:_____Name of Doctor_____

GENERAL HISTORY:

heart	slurred speech	ear injury
hypertension	blurred vision	head injury
hypotension	stroke	anxiety
circulation	confusion	nicotine
anemia	loss of consciousness	alcohol
diabetes	high cholesterol	caffeine
		salt

NEURO-OTOLOGICAL EXAMINATION:

ROMBERG: BRUITS:

COORDINATION: NYSTAGMUS: