

**Patient's Details:**

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Phone/Mobile: \_\_\_\_\_

\_\_\_\_\_

Gender:  Female  Male

**The following questions refer to your  
feeling of dizziness.  
Please fill in all the blanks.**

Please describe in your own words the off balance/vertigo/  
dizzy symptom sensation you CURRENTLY feel without using  
the word "dizzy". If there are more than one distinct type of  
sensation please describe both:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe if any significant events which led up to the  
CURRENT off balance/vertigo/dizzy symptom sensation you  
feel (eg cold or flu symptoms, flight, head trauma):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you have had vertigo/dizziness prior to current symptoms  
please describe if any significant events which led up to THE  
VERY FIRST initial off balance/vertigo/dizzy symptom sensation  
ever experienced, even if was years ago (eg cold or flu  
symptoms, flight, head trauma):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe in your own words the off balance/vertigo/  
dizzy symptom sensation you experienced THEN without using  
the word "dizzy". If there are more than one distinct type of  
sensation please describe both:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe how long the symptoms lasted for and if  
symptoms changed:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

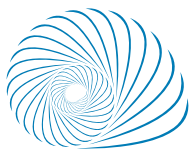
Do you ever have any of the following sensations? Select only  
those that apply.

- Spinning in circles
- Falling to one side
- World spinning around you

**To contact us:**

Phone: **1300 CLARITY (1300 252 748)**  
Email: [enquiries@clarityhearingsolutions.com.au](mailto:enquiries@clarityhearingsolutions.com.au)  
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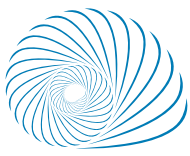
The following questions refer to typical dizzy spells. Select only those that apply and answer as appropriate.

- Do your dizzy spells come in attacks?  
How often? \_\_\_\_\_  
How long do/did the attacks last for? Seconds/minutes/hours/days/weeks/months/constant: If more than one type of dizziness describe both:  
\_\_\_\_\_  
\_\_\_\_\_  
Date of first spell/attack? \_\_\_\_\_
- Are you currently feeling dizzy?
- Are you free from dizziness between attacks?
- Are you dizzy or unsteady constantly?
- Do you get any warning the dizziness is about to start?  
What are the warning signs?  
\_\_\_\_\_
- Are you dizzy at certain times of the day or night?  
If so which? \_\_\_\_\_
- Did you take any medications (inc strong antibiotics, chemotherapy, quinine etc) prior to symptom onset?  
If yes what were they?  
\_\_\_\_\_  
\_\_\_\_\_
- Did you have any cold or flu like symptoms prior to onset?
- Does your hearing change with an attack?
- Do you only get dizzy when you move?
- Are you dizzy mainly when you sit or stand up quickly?
- Are you dizzy when you look up, down or bend forward or backwards?  
If so which? \_\_\_\_\_
- Are you dizzy if you roll over in bed?  
If so in the right or left side? \_\_\_\_\_
- Are you dizzier in certain positions?  
Which position?  
\_\_\_\_\_
- Are you nauseated during an attack?
- Are you dizzy even when lying down?
- Does closing your eyes make your dizziness worse?
- Are you better if you sit or lie perfectly still?
- Have you had a recent cold or flu preceding recent dizzy spells?
- Have you had fullness, pressure, or ringing in your ears?
- Have you had pain or discharge in your ear of recent onset?
- Do you have a loss of balance when walking in dark?  
If so veering to the right or left? \_\_\_\_\_

- Do you have a loss of balance when walking in the light?  
If so veering to the right or left? \_\_\_\_\_
- Do loud sounds make you dizzy?
- Do you get dizzy when you cough, sneeze, blow nose, bowel movement or other?  
If so which?  
\_\_\_\_\_
- Are your symptoms exasperated or initiated when in upright posture eg. standing or sitting?  
\_\_\_\_\_
- Are your symptoms exasperated or initiated when in motion eg. walking, driving, flying etc?  
\_\_\_\_\_
- Are your symptoms exasperated or initiated when not in motion but visual stimuli gives impression of moving (eg. sitting in car and cars beside you move giving sensation of movement)?  
\_\_\_\_\_
- Are your symptoms exasperated or initiated with seeing moving objects or complex visual patterns (eg. computer/TV screens with moving images, patterned carpets, clothes or pictures)?  
\_\_\_\_\_

Any other comments about your dizziness you feel is pertinent?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



The following refer to other sensations you may have. Select only those that apply and answer as appropriate.

- Do you black out or faint when dizzy?
- Have you had:
  - Severe or recurrent headaches or migraines?
  - Light and/or sound sensitivity leading up to or during your headaches or dizziness/vertigo?
  - Visual Auras (eg. lines, spots, squiggles) leading up to or during your headaches or dizziness/vertigo?
  - Any double or blurry vision?
  - Numbness in your face, ears or extremities?  
If so both sides, left or right? \_\_\_\_\_
  - Weakness or clumsiness in arms, legs?
  - Pain in the neck or shoulders?
  - Slurred or difficult speech?
  - Difficulty swallowing?
  - Tingling around your mouth?
  - Spots before your eyes?
  - Jerking of arms or legs?
  - Seizures?
  - Confusion or memory loss?
  - Recent head trauma? (If yes, please explain).

\_\_\_\_\_

Any other sensation variables you feel are pertinent to your condition?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The following refers to your hearing. Select only those that apply and indicate which side has been affected:

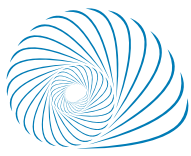
- Difficulty hearing in one ear?  
 Left  Right  Both
- Ringing or buzzing in one ear?  
 Left  Right  Both
- Fullness in one ear?  
 Left  Right  Both
- Change in hearing and tinnitus volume when dizzy?
- Does your hearing fluctuate?
- Can you hear your heartbeat, eyes blinking, or any other internal sounds? Which sound and which ears?  
\_\_\_\_\_  
 Left  Right  Both
- Own voice excessively loud?  
 Left  Right  Both

Any other variables to do with your hearing you feel are pertinent?:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any of the following?

- Pain in ears?  
 Left  Right  Both
- Discharge from ears?  
 Left  Right  Both
- Hearing change for the better?  
 Left  Right  Both
- Hearing change for the worse?  
 Left  Right  Both
- Exposure to loud noises?
- Previous ear infections?
- Trauma to your ear(s)?
- Previous ear surgery?  
What? \_\_\_\_\_
- Family history of deafness?



The following refer to habits and lifestyle.  
Select only those that apply and answer as  
appropriate.

Is there added stress to your life recently?

Is your dizziness related to:

- Moments of stress?
- Menstrual period?
- Overwork or exertion?
- Hunger?
- Emotional upset?
- Changes in weather/atmospheric pressure?
- Do you feel light-headed or have a swimming sensation when you are dizzy?
- Do you find yourself breathing faster or deeper when excited or dizzy?
- Did you recently change eyeglasses?
- Have you ever had weakness or faintness a few hours after eating?

Is your dizziness related to any of the following?

- Do you drink coffee?  
How much and how often? \_\_\_\_\_
- Do you drink tea?  
How much and how often? \_\_\_\_\_
- Do you drink soft drinks?  
How much and how often? \_\_\_\_\_
- Do you drink alcohol?  
How much and how often? \_\_\_\_\_
- Do you smoke?  
What? \_\_\_\_\_  
How much and how often? \_\_\_\_\_

Describe any other variables you feel may contribute to your dizziness:

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### Past medical history

Please list your current medical problems and length of illness:

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Please list all surgery performed and approximate dates:

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Please list all allergies (including drugs) and reaction:

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Please list all medicines you currently take for your dizziness that HAVE provided some relief or benefit with your symptoms:

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Please list all medicines you currently take for your dizziness that HAVE NOT provided some relief or benefit for you:

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Please list all medicines you currently take (including pain medicine, nonprescription medicine, nerve pills, sleeping pills, or birth control pills).

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Have you had any previous testing eg hearing, x-rays, head scans, etc?

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## Family history

Any family history of any of the following? Select all that apply.

- Migraine?
- Off Balance/Vertigo/Dizziness or tinnitus?
- High blood pressure?
- Low blood pressure?
- Diabetes?
- Low blood sugar?
- Thyroid disease?
- Asthma?
- Multiple Sclerosis?

Please list any other diseases that run in your immediate family:

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Any other comments you feel are pertinent to your condition:

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## Declaration

I confirm that for my appointment I will:

- Not wear make-up
- Not eat anything for 8 hours prior
- have no caffeine for 12 hours prior
- Have no alcohol for 48 hours prior
- Have no nicotine (cigarettes, gum, patches etc) for 12 hours prior
- Not take - tranquilisers, sedatives, vestibular suppressants (eg Stemetil, Serc) and painkillers for 24 hours prior
- All information on this form is true and accurate

Signature

## Submit via email or fax

Please complete and sign this questionnaire and submit to

**Email:** enquiries@clarityhearingsolutions.com.au.

**Fax:** Brisbane/South East Qld - 07 3366 5533  
Mackay - 07 4957 2211  
Townsville/Regional Qld - 07 4779 1866