

ASSOCIATED NEUROLOGICAL SPECIALTIES

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Patient Name: _____ Today's Date: _____

CHIEF COMPLAINT-DIZZINESS

1. Define that dizziness means to you without using the word "dizzy"?

2. Do you feel that you are spinning with your dizziness?

3. Do you feel that you are lightheaded with your dizziness?

4. Do you feel as if you are drunk or overdosed with the dizziness?

5. Is the dizziness worse when you get up out of a chair or get up out of bed at night?

6. Is the dizziness worse when you move your head from side-to-side or look over your shoulder?

7. How long have you had the dizziness?

8. Is the dizziness worse when you roll over in bed?

9. What medication have you taken for the dizziness?

10. Did the medication help?

11. Was the medication tolerable?

CHIEF COMPLAINT-DIZZINESS- CONTINUED:

12. Are you gradually getting better or is the dizziness constant?

13. Have you had any head trauma to cause the dizziness?

14. Have you had any other neurologic symptomatology in the past?

15. Do you have any loss of hearing?

16. Do you experience any ringing or buzzing in your ears or tinnitus?

17. Do you have any other neurologic symptoms in balance, gait disturbance, or visual disturbance?

18. Do you have headaches?

19. Do you have any numbness or tingling with the dizziness?

20. Have you ever had any imaging studies? _____ If so, where?

21. Have you had any neurophysiologic studies? _____ If so, what?