APPENDIX C

PERFORMA FOR INDIVIDAUL WITH DIZZINESS

DEMOGRAPHIC DATA

Name:

D.O.B:

D. O. A:

Age/Sex:

Language:

Informant:

Occupation:

Referred by:

Address:

Contact no:

Supervisor:

Clinician:

Chief compliant: (Self & informant)

How would you describe the sensation that you are feeling?

Do you have any of the following symptoms?

A. Otologic/ Ear system

1. Complaint of reduced/difficulty in hearing sensitivity? present/absent

If present then which ear, specify? Both ears/Right/Left

Duration:

Onset: Sudden/Gradual

Nature of hearing loss: Progressive/ Static/ Fluctuating

Does your hearing fluctuate with your attack of giddiness?

2. Complaint of difficulty in understanding speech: present/ absent

If present, then all situations/ in presence of noise only

Duration:

3. Compliant /history of blocking sensation: Present/ absent

If present, then in which ear (specify)? Both ears/Right/Left

4. Compliant/history of any discharge or ear infections?: Present /absent

If present, then in which ear (specify)? Both ears/Right/Left

5. Complaint / history of ear pain? Present/ absent

If present, then in which ear (specify)? Both ears/Right/Left

6. History of injury to the ear/head? Present/ absent

If yes, details:

7. Complaint of intolerance to sound: Present/ absent

If present: since

Specify to which sound

8. Complaint of tinnitus/ringing sound in the ears? Present/ absent

Which ears: Both ears/Right/Left?

Describe the noise/tinnitus

Does the noise/tinnitus change with dizziness?

9. Have you had ear surgery? (History of ear surgery)

B. Eye disorders/Ocular:

1. Blurred vision or blindness. Constant In episodes

2. Double vision Constant In episodes

3. Spots before the eyes Constant In episodes

Describe:

4. Difficulty walking in the dark:

C. <u>Central Nervous system/Neurological disorders:</u>

1. 1.Gross weakness in the upper/lower limbs: Present/Absent
2. Any loss of sensation of upper/lower limbs of body: Present/Absent
3. Any difficulty swallowing: Present/Absent
4. Any difficulty in speaking: Present/Absent
5. Tingling around the mouth: Present/Absent
6. Complaint/history of headache: Present/Absent
7. Complaint of unconsciousness: Present/Absent
8. Have you experienced any numbness of the face, arms, or legs?: Present/Absent
9. Face/ Eye paralysis: Present/Absent
10. History of recurrent or severe headache.: Present/Absent

D. **<u>Dizziness related:</u>**

Chronology

1. Onset of dizziness

2. Is your dizziness constant or does it occur in attacks?

3. If episodic, how often are the attacks and what is the duration of the attacks?

4. What are the dates of your attacks?

5. Are you free of dizziness between the attacks and do you have any warning before an attacks?

6. Does your dizziness begin when you awaken in the morning?

7. Do you have any history of morning sickness'?

8. Have you had any recent cold or flu preceding the recent dizzy spell?

9. Do loud sound make you dizzy?

Preceding Events, Trigger mechanism

Is there a specific event that preceded your dizziness?

a. Is ravelling in air / car / train
b. Swimming of the diving
c. Turning of the head
d. Bending down
e. Suddenly standing up

f. Gazing to right / left
g. No trigger known.

How do you feel when you have dizziness

1. Lightheadedness / swimming sensation in head. YES / NO
2. Sudden blacking out
3. Turning / falling
4. Tendency to fall: to the Right? Left? Forward? Backward?
5. Loss of Balance when walking: Veering right? Veering Left?
6. Pressure in the head.
7. Do you have any nausea or vomiting during these attacks?
8. Swaying
9. Surrounding objects – surrounding objects moving but head stable
   - Surrounding objects stable but head moving
10. Rotating / Spinning sensation
11. Unconsciousness

Other factors

1. Is there anything that will stop or make your dizziness feel better?
2. Do you get dizzy after exertion or overwork?
3. Do you tend to get upset easily?
4. Do you get dizzy when you have not eaten in a long time?
5. Is you dizziness connected with your menstrual period?
6. Do you smoke? YES / NO
7. Do you drink alcohol? YES / NO
8. If so, how many drinks do you have in a day?
   _____Weekly:_____
9. Do you use tobacco in any form? How much?
   _____
10. Do you have high blood pressure? _____
11. When was your last dose? _____
12. Any cardiac or other medical issues? _____
13. Any Family history of dizziness or balance problems_____
14. Have you ever had a neck injury?
15. Have you taken treatment for dizziness? If yes, please give details_____

When did the dizziness first occur?_____

If in attacks: How often? _____

How long do they last? _____

Cardiovascular disorders

a. Hypertension
b. Hypotension
c Arteriosclerosis
d. H/O cardiac surgery

Other a. Diabetic mellitus

c. Kidney disorder

Have you taken any of the following medicines?

a. Quinine
b. Nicotine
c. Caffeine
d. Salicylates
e. Gentamycin
f. Streptomycin
g. Contraceptives
h. Sediatives
i. Psychiatric drugs
j. Other
   - ✓ Recurrent headaches /history of migrane
   - ✓ Muscle twitching in some parts of body and epileptic fits.

System Review: By symptoms

1. Recent weight loss fever fatigue
2. Cardiovascular : Chest pain

   Swelling of leg

   Leg pain with walking

3. Respiratory : Wheezing cough_____
4. Musculoskeletal : Neck pain
5. Endocrinal : Thyroid problem
6. Hemato logic: Bleeding problem, Anemia, etc.
7. Please List any other recent medical problem & length of illness & medicines that you are taking.
8. Please List all allergies & reaction.