

DIZZY QUESTIONNAIRE

Patient's Name: _____ Date: _____

Please read through the entire questionnaire first, then circle yes or no to describe your feelings most accurately. Answer all questions accurately and completely (fill in the blanks).

When you are dizzy, do you experience any of the following sensations?

- | | | |
|-----|----|---|
| Yes | No | Lightheadedness or swimming sensation in your head? |
| Yes | No | Blacking out or loss of consciousness? |
| Yes | No | Tendency to fall to the right? |
| Yes | No | Tendency to fall to the left? |
| Yes | No | Tendency to fall forward? |
| Yes | No | Tendency to fall backwards? |
| Yes | No | Objects spinning or turning around you? |
| Yes | No | Sensation that you are turning or spinning inside, with the outside objects remaining stationary? |
| Yes | No | Loss of balance when walking - veering to the right? |
| Yes | No | Loss of balance when walking - veering to the left? |
| Yes | No | Headache? |
| Yes | No | Nausea or vomiting? |
| Yes | No | Pressure in the head? |
| Yes | No | My dizziness is constant. |
| Yes | No | My dizziness is in attacks. |
| Yes | No | If in attacks, how often? _____ |
| | | How long do they last? _____ |
| | | When was the last attack? _____ |
| | | When did the dizziness first occur? _____ |
| Yes | No | Do you have any warning that the attack is about to start? |
| Yes | No | Do they occur at any particular time of day or night? If yes, what time. _____ |
| Yes | No | Are you completely free of dizziness between attacks? |
| Yes | No | Does change of position make you dizzy? |
| Yes | No | Do you have trouble walking in the dark? |
| Yes | No | When you are dizzy, must you support yourself standing? |
| Yes | No | Do you know of any possible cause of your dizziness? If so, what? _____ |
| Yes | No | Do you know of any thing that will stop you dizziness or make it better? If so what? _____ |
| Yes | No | Do you know of any thing that will make your dizziness worse? If so, what? _____ |

Patient's Name: _____ Date: _____

Yes No Were you exposed to any irritating fumes, paints, etc at the onset of your dizziness?

Yes No Do you have any allergies? If yes, to what? _____

Yes No Did you ever have an injury to your head? If yes, were you unconscious? Yes No

Yes No Do you take medications regularly? If yes, list name and dosage

Yes No Do you use tobacco of any form? If yes, what kind and how much?

Do you have any of the following symptoms? Circle yes or no and ear involved.

Yes No Difficulty hearing? BOTH RIGHT LEFT

Yes No Noise in ear? BOTH RIGHT LEFT

If yes, describe the noise: _____

Yes No Does the noise change with dizziness? BOTH RIGHT LEFT

If yes, how? _____

Yes No Fullness/Stiffness in your ears? BOTH RIGHT LEFT

Yes No Pain in your ears? BOTH RIGHT LEFT

Yes No Discharge from your ears? BOTH RIGHT LEFT

Have you experienced any of the following symptoms? Circle yes or no and circle if constant or in episodes.

Yes No Double/blurred vision or blindness? CONSTANT EPISODES

Yes No Numbness of face or extremities? CONSTANT EPISODES

Yes No Weakness in arms or legs? CONSTANT EPISODES

Yes No Clumsiness in arms or legs? CONSTANT EPISODES

Yes No Confusion or loss of consciousness? CONSTANT EPISODES

Yes No Difficulty with speech? CONSTANT EPISODES

Yes No Difficulty with swallowing? CONSTANT EPISODES

Yes No Pain in the neck or shoulders? CONSTANT EPISODES

Comments: _____