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? _____

Continued on Page Two

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/Stuffiness 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: _____
_____