DIZZINESS QUESTIONNAIRE

NAME: ___________________________________ SEX: Male Female AGE: ___________

When you are 'dizzy', do you first experience any of the following sensations? Please read the entire list first and check the appropriate answers.

1. Lightheadedness: □ YES □ NO
2. Swimming sensation in head: □ YES □ NO
3. Blacking out: □ YES □ NO
4. Loss of consciousness: □ YES □ NO
5. Tendency to fall: □ YES □ NO □ to the right □ to the left
6. Objects spinning or turning around: □ YES □ NO
7. Sensation that you are turning or spinning inside, while outside objects remain stationary: □ YES □ NO
8. Loss of balance when walking: □ YES □ NO
9. Headache: □ YES □ NO
10. Nausea or Vomiting: □ YES □ NO
11. Pressure in head: □ YES □ NO

Please circle the appropriate answer and fill in any blanks.

1. My dizziness is: □ Constant □ In attacks
2. When did dizziness first occur? ______________________________
3. If in attacks: How often? ______________________ How long do they last? ______________________
4. Are you completely free of dizziness between attacks? □ YES □ NO
5. Does your dizziness occur only in certain positions? □ YES □ NO
6. Do you have trouble walking in the dark? □ YES □ NO
7. When dizzy, must you support yourself when standing? □ YES □ NO
8. Do you know of any possible cause of your dizziness? □ YES □ NO
9. Do you know of anything that will:
   Stop your dizziness ______________________
   Make your dizziness worse ______________________
   Precipitate an attack ______________________
10. Were you exposed to any irritating fumes, paints, etc. at the onset of dizziness? □ YES □ NO
11. Do you have any allergies? □ YES □ NO
12. Did you ever injure your head? □ YES □ NO Were you conscious? ______________
13. Did you ever have a neck injury? □ YES □ NO When? ______________
14. Did you ever have a whiplash injury? □ YES □ NO When? ______________
15. Do you take any medications regularly? □ YES □ NO List: ______________

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16. Do you use tobacco in any form? □ YES □ NO Explain: ______________
17. Do you use alcohol? □ YES □ NO Explain: ______________
18. Have you ever had ear surgery? □ YES □ NO Explain: ______________

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19. Do you drink coffee? □ YES □ NO How much? ______________

Do you have any of the following symptoms?

1. Difficulty hearing? □ YES □ NO □ Right ear □ Left ear □ Both ears
When did this begin? ______________________ Is it getting worse? ______________________
2. Noise in your ears? □ YES □ NO □ Right ear □ Left ear □ Both ears
Describe: ____
Does noise change when dizzy? □ YES □ NO Explain: ______________________
3. Fullness or stuffiness in ears? □ YES □ NO □ Right ear □ Left ear □ Both ears
Does this change when dizzy? □ YES □ NO
4. Pain in ears? □ YES □ NO □ Right ear □ Left ear □ Both ears
5. Discharge from ears? □ YES □ NO □ Right ear □ Left ear □ Both ears
6. Double vision? □ YES □ NO □ Constant □ In episodes
7. Numbness in face or extremities? □ YES □ NO □ Constant □ In episodes
8. Blurred vision or blindness? □ YES □ NO □ Constant □ In episodes
9. Weakness in arms or legs? □ YES □ NO □ Constant □ In episodes
10. Clumsiness in arms or legs? □ YES □ NO □ Constant □ In episodes

11. Confusion or loss of consciousness? ☐ YES ☐ NO ☐ Constant ☐ In episodes
12. Difficulty with speech? ☐ YES ☐ NO ☐ Constant ☐ In episodes
13. Difficulty with swallowing? ☐ YES ☐ NO ☐ Constant ☐ In episodes
14. Tingling around mouth? ☐ YES ☐ NO ☐ Constant ☐ In episodes
15. Spots before eyes? ☐ YES ☐ NO ☐ Constant ☐ In episodes
16. Do you get dizzy after exertion or overwork? ☐ YES ☐ NO
17. Did you get new glasses recently? ☐ YES ☐ NO
18. Do you tend to get upset easily? ☐ YES ☐ NO
19. Do you get dizzy when you have not eaten for a long time? ☐ YES ☐ NO
20. Is your dizziness connected with your menstrual period? ☐ YES ☐ NO

Comments: