DIZZINESS QUESTIONNAIRE

Thank you for your cooperation in filling out this brief questionnaire.

Name:_____ Date:_____

I. *When you are "dizzy" do you experience any of the following symptoms? (check **yes** or **no**)*

1. Light-headedness or swimming sensation in the head? ☐ Yes ☐ No
2. Blacking out or loss of consciousness? ☐ Yes ☐ No
3. Tendency to fall? ☐ to the left? ☐ to the right? ☐ forward? ☐ backward?
4. Objects spinning or turning around you? ☐ Yes ☐ No
5. Sensation that you are spinning or turning? ☐ Yes ☐ No
6. Loss of balance while walking? ☐ veering to the left? ☐ veering to the right?
7. Headache? ☐ Yes ☐ No
8. Nausea or vomiting? ☐ Yes ☐ No
9. Pressure in the head? ☐ Yes ☐ No
10. Tingling in your fingers, toes or around your mouth? ☐ Yes ☐ No

II. *Please check **yes** or **no** and fill in the blanks **answering all questions**.*

1. My dizziness is: ☐ Constant? ☐ In attacks or episodes?
2. When did the dizziness first occur? _____
3. If in attacks: How often do attacks occur? _____
   How long do they last? _____
   When was the first episode? _____
   What was the duration of the shortest attack? _____
   Do you have any warning that it is going to occur? ☐ Yes ☐ No
   Do they occur at any particular time of day or night? ☐ Yes ☐ No
   Are you completely free of dizziness between attacks? ☐ Yes ☐ No
4. Does change of position make you dizzy? ☐ Yes ☐ No
5. Do you have trouble walking in the dark? ☐ Yes ☐ No
6. When you are dizzy, must you support yourself when standing? ☐ Yes ☐ No
7. Do you know any possible cause of your dizziness? ☐ Yes ☐ No
8. Do you know of anything that will:
   Stop your dizziness or make it better? _____
   ☐ Yes ☐ No
   Make your dizziness worse? _____
   ☐ Yes ☐ No
   Precipitate an attack? _____
   ☐ Yes ☐ No
   (e.g.: fatigue, exertion, hunger, menstrual period, stress, emotional upset, alcohol)
9. Were you exposed to any irritating fumes, paints, etc. at the onset of dizziness?
   ☐ Yes ☐ No

III. *Past medical history*

1. Do you have a history of any of the following? **Please check all that apply.**

☐ heart disease ☐ hypertension ☐ kidney disease ☐ thyroid disease ☐ migraine headaches

2. Do you have any family history of any of the following? **Please check all that apply.**

☐ ear disease ☐ neurological disease ☐ migraine headache

3. Do you take any medicines regularly? If yes, please list: _____ ☐ Yes ☐ No

_____

4. Are you allergic to any medications? If yes, please list: _____ ☐ Yes ☐ No

_____

5. Have you ever suffered a serious head injury or been knocked unconscious? ☐ Yes ☐ No

6. Do you use tobacco in any form? _____ ☐ Yes ☐ No

How much? _____ For how long? _____

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

1. Difficulty in hearing? ☐ Yes ☐ No ☐ Both ears ☐ Right ear ☐ Left ear ☐ **Associated with Attack**
2. Noise in your ears? ☐ Yes ☐ No ☐ Both ears ☐ Right ear ☐ Left ear ☐ **Associated with Attack**

Describe the noise: _____

3. Does the noise change with dizziness, and if so, how? _____ ☐ Yes ☐ No

_____

4. Pain in your ears? ☐ Yes ☐ No ☐ Both ears ☐ Right ear ☐ Left ear ☐ **Associated with Attack**
5. Fullness or stuffiness in your ears?

☐ Yes ☐ No ☐ Both ears ☐ Right ear ☐ Left ear ☐ **Associated with Attack**

6. Discharge from your ears?

☐ Yes ☐ No ☐ Both ears ☐ Right ear ☐ Left ear ☐ **Associated with Attack**

V. *Have you experienced any of the following symptoms? Check **yes** or **no** and if **constant** or in **episodes**.*

1. Double or blurred vision or blindness?	☐ Yes	☐ No	☐ Constant	☐ Episodes
2. Numbness of face?	☐ Yes	☐ No	☐ Constant	☐ Episodes
3. Numbness of arms and legs?	☐ Yes	☐ No	☐ Constant	☐ Episodes
4. Weakness in arms or legs?	☐ Yes	☐ No	☐ Constant	☐ Episodes
5. Clumsiness in arms or legs?	☐ Yes	☐ No	☐ Constant	☐ Episodes
6. Confusion or loss of consciousness?	☐ Yes	☐ No	☐ Constant	☐ Episodes
7. Difficulty of speech?	☐ Yes	☐ No	☐ Constant	☐ Episodes
8. Difficulty with swallowing?	☐ Yes	☐ No	☐ Constant	☐ Episodes
9. Pain in neck or shoulder?	☐ Yes	☐ No	☐ Constant	☐ Episodes