Dizziness Questionnaire

NAME:_____ DATE: _____

I. **Which of these best describes your dizziness? Circle only one**.

- ☐ A sensation of movement of yourself or the room: spinning, tilting, or wave-like movement
- ☐ Lightheadedness or feeling that you are going to faint
- ☐ Loss of balance
- ☐ Disassociation or disorientation with the world

II. When you are "dizzy" do you experience any of the following sensations? You may circle as many yes responses as necessary.

☐ Yes	☑ No	1.	Lightheadedness or swimming sensation in the head.
☐ Yes	☑ No	2.	Blacking out or loss of consciousness.
☐ Yes	☑ No	3.	Tendency to fall.
☐ Yes	☑ No	4.	Objects spinning or turning around you.
☐ Yes	☐ No	5.	Sensation that you are turning or spinning inside.
☐ Yes	☐ No.	6.	Loss of balance when walking
☐ Yes	☑ No	7.	Headache
☐ Yes	☐ No	8.	Pressure in the head.
☐ Yes	☐ No	9.	Nausea or vomiting.

III. Please fill in the blanks or circle appropriate answer

A. When did the dizziness first occur?_____

B. Is the dizziness CONSTANT or does it come in ATTACKS?

C. If the dizziness comes in attacks, how often do these attacks occur?
_____times per day / week / month / year.

D. If the dizziness comes in attacks, how long do the attacks last? _____
seconds / minutes / hours / days.

E. What factors provoke the dizziness or make the dizziness worse?
_____

F. What makes the dizziness better?
_____

G. Does your hearing change when the dizziness occurs? No
How?_____
Which Ear? -

H. Are there any other symptoms associated with the dizziness, such as visual changes, numbness or tingling in the arms or legs, weakness in the arms or legs, changes in speech?
_____

I. Are you completely free of dizziness between attacks? Yes

J. Have you ever been diagnosed with a head or neck injury? No

K. Do you have any history of a neurological disease such as migraine, multiple sclerosis or stroke?
Circle Yes / No Explain

_____

IV. Do you have any of the following symptoms? Please circle Yes or No and circle Ear involved.

☐ Yes ☐ No 1. Difficulty in hearing? ☐ Right ☐ Left
☐ Yes ☐ No 2. Noise in your ears? ☐ Right ☐ Left
☐ Yes ☐ No 3. Does noise change during the dizziness? How? _____
☐ Yes ☐ No 4. Fullness or stuffiness in your ears? ☐ Right ☐ Left

V. Have you experienced any of the following symptoms?

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

VI. Please list medications you are currently taking on a regular basis:

_____

_____

Please check below for any MEDICATIONS you have tried or are currently taking for dizziness:

	Taken in Past	**Taking Now**	**Helps**
Antivert (Meclizine)	☐	☐	☐ YES NO ☐
Valium (Diazepam)	☐	☐	☐ YES NO ☐
Diazide "water pills"	☐	☐	☐ YES NO ☐

VII. Have you ever been previously evaluated for dizziness?

No How Long Ago? _____ Result? _____

_____

_____

VIII. Additional Comments:

_____

_____