DIZZINESS QUESTIONNARIE

Patient Name_____

Date_____

To help us understand your dizziness better, please complete this form.

I. When you are dizzy, do you experience any of the following sensations? Please read the entire list first, then put an "x" in the box that applies.

YES NO

( ) ( ) 1. Lightheadedness
( ) ( ) 2. Swimming sensation in the head
( ) ( ) 3. Blacking out
( ) ( ) 4. Loss of consciousness
( ) ( ) 5. Tendency to fall: To the right?
( ) ( ) To the left?
( ) ( ) Forward?
( ) ( ) Backward?
( ) ( ) 6. Objects spinning or turning around you.
( ) ( ) 7. Sensation that you are spinning or turning inside with outside objects remaining stationary.
( ) ( ) 8. Loss of balance when walking: Veering to the right?
( ) ( ) Veering to the left?
( ) ( ) 9. Headache
( ) ( ) 10. Nausea or vomiting
( ) ( ) 11. Pressure in the head

II. Please check either "yes" or "no" and fill in the black space if applicable.

YES NO

( ) ( ) 1. My dizziness is: constant?
( ) ( ) in attacks?
When did dizziness first occur?
_____
( ) ( ) If in attacks, how often and how long do they last?
( ) ( ) _____
( ) ( ) 2. Do you have a warning that the attack is about to start?
( ) ( ) 3. Are you completely free of dizziness between attacks?
( ) ( ) 4. Does dizziness occur only in certain positions?
( ) ( ) 5. Do you have trouble walking in the dark?
6. When dizzy, must you support yourself when standing?
7. Do you know of any possible cause of your dizziness? If yes, what?
( ) ( ) _____
( ) ( ) _____
( ) ( ) _____
( ) ( ) **Do you know of anything that will:**
( ) ( ) 8. Stop your dizziness or make it better?
( ) ( ) 9. Make your dizziness worse?
( ) ( ) 10. Precipitate an attack?

11. Were you etc., at the onset of dizziness?
exposed to any12. Did you ever injure your head?
irritating If yes, were you unconscious?
fumes, paints, 13. Have you ever had ear surgery?

Dizziness Questionnaire-continued

III. Do you have the following symptoms? Put and "x" in appropriate box and circle the ear involved.

YES NO

( ) ( ) Both ears Right Left
When did this first start?
( ) ( ) _____
( ) ( ) Is is getting worse?
2. Noise in your ears? Both ears Right Left
( ) ( ) Describe the
noise_____
( ) ( ) ____
( ) ( ) Is the noise present with the dizziness?
( ) ( ) If yes, how?
( ) ( ) _____
( ) ( ) _____
1. Does anything stop the noise or make it better?
Difficulty 3. Fullness/stuffiness in your ears? Both ears Right Left
hearing? Does this change when you are dizzy?
4. Pain in your ears? Both ears Right Left
5. Discharge from your ears? Both ears Right Left

IV. Have you had any of the following symptoms? Put an "x" in the appropriate box and circle if "constant" or in "episodes".

YES NO

( ) ( ) 1. Double vision Constant Episodes
( ) ( ) 2. Numbness of face or extremities Constant Episodes
( ) ( ) 3. Blurred vision or blindness Constant Episodes
( ) ( ) 4. Weakness in arms or legs Constant Episodes
( ) ( ) 5. Clumsiness in arms or legs Constant Episodes
( ) ( ) 6. Confusion or loss of consciousness Constant Episodes
( ) ( ) 7. Difficulty with speech Constant Episodes
( ) ( ) 8. Difficulty with swallowing Constant Episodes
( ) ( ) 9. Tingling around mouth Constant Episodes
( ) ( ) 10. Spots before eyes Constant Episodes

V. Please check box for either "yes" or "no".

YES NO

( ) ( )
( ) ( )
( ) ( )
( ) ( )
( ) ( )
( ) ( )

1. Do you get dizzy after exertion or overwork?
2. Did you get new glasses recently?
3. Do you tend to get upset easily?
4. Do you get dizzy when you have not eaten for a long time?
5. Is you dizziness connected with you menstrual period?
6. Have you ever had a neck injury?