DIZZINESS QUESTIONNAIRE

Name _____ DOB _____ Date _____

I When you are "dizzy" do you experience any of the following sensations?

Please read the entire list first. Then check "**yes**" or "**no**" to describe your feelings most accurately.

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: T the right?
Yes No To the left?
Yes No Forward?
Yes No Backward?
Yes No 4. Objects spinning or turning around you?
Yes No 5. Sensation that you are turning or spinning inside, with outside objects remaining stationary?
Yes No 6. Sensation of the environment moving up and down while you walk?
Yes No 7. Loss of balance when walking: eering to the right?
Yes No Veering to the left?

Yes No 9. Nausea or vomiting?
Yes No 10. Pressure in the head?
Yes No 11. Palpitations, perspiration, shortness of breath, or a feeling of panic?

II Please check "**yes**" or "**no**" and fill in the blank spaces. **Answer <u>all</u> questions.**

Yes No 1. My dizziness is: Cnstant?
Yes No In attacks?
2. When did dizziness first occur? _____
3. If in attacks: How often? _____
How long do they last? _____
When was the last attack? _____

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?
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 of any possible cause of your dizziness? What? _____

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? _____

(Fatigue? Exertion? Hunger? Menstrual Period? Stress? Emotional? Upset?)

◯ Yes ◯ No 9. Were you exposed to any fumes, paints, etc., at the onset of dizziness?

◯ Yes ◯ No 10. **If you are allergic to any medications**, please list: _____

◯ Yes ◯ No 11 If you ever injured your head, were you unconscious?

◯ Yes ◯ No 12. **If you take any medications** regularly, for any reason, please list:

_____

13. Do you use any tobacco in any form? How much? _____

III Do you have any of the following symptoms? Please check "**yes**" or "**no**" and check ear involved.

◯ Yes ◯ No ◯ Both ears ◯ Left ◯ Right

◯ Yes ◯ No ◯ Both ears ◯ Left ◯ Right

2a. How loud is your tinnitus or head noise most of the time?

◯ None (No head noise)

◯ Very Soft (Heard only in a quiet situation)

◯ Moderate (Heard only in an ordinary situation)

◯ Loud (Heard and noticed in all situations, even when concentrating on something else)

2b. Describe the noise. _____

2c. Does noise change with dizziness? If so, how? _____

◯ Yes ◯ No Pain in your ears? ◯ Both ears ◯ Left ◯ Right

◯ Yes ◯ No Discharge from your ears? ◯ Both ears ◯ Left ◯ Right

IV Have you ever experienced any of the following symptoms? Please check "**yes**" or "**no**" and check "**constant**" or "**in episodes**".

◯ Yes	◯ No	1. Double vision, blurred vision or blindness?	◯ Constant	◯ In Episodes
◯ Yes	◯ No	2. Numbness of face?	◯ Constant	◯ In Episodes
◯ Yes	◯ No	3. Numbness of arms or legs?	◯ Constant	◯ In Episodes
◯ Yes	◯ No	5. Weakness in arms or legs?	◯ Constant	◯ In Episodes
◯ Yes	◯ No	6. Clumsiness or arms or legs?	◯ Constant	◯ In Episodes
◯ Yes	◯ No	7. Confusion or loss of consciousness?	◯ Constant	◯ In Episodes
◯ Yes	◯ No	8. Difficulty with speech?	◯ Constant	◯ In Episodes
◯ Yes	◯ No	9. Difficulty with swallowing?	◯ Constant	◯ In Episodes
◯ Yes	◯ No	10. Pain in the neck or shoulder?	◯ Constant	◯ In Episodes
◯ Yes	◯ No	11. Seasickness or car sickness?	◯ Constant	◯ In Episodes

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