**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: To 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: Veering to the right?
Yes □ No □ Veering to the left?
Yes □ No □ 8. Headache.
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 all questions.

1. My dizziness is:
Yes □ No □ Constant?
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? _____
8. Do you know of anything that will:
Yes □ No □ 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 irritating 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 medication regularly, for any reason, please list:_____
_____
Yes □ No □ 13. Do you use tobacco in any form, how?_____How much?_____

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

Yes □ No □ 1. Difficult in hearing? Both ears □ Right □ Left □

Yes □ No □ 2. Noise in your ears? Both ears □ Right □ Left □

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 □ 3. Fullness or stuffiness in our ears? Both □ Right □ Left □

Yes □ No □ 4. Pain in your ear? Both □ Right □ Left □

Yes □ No □ 5. Discharge from your ears? Both □ Right □ Left □

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 of legs. Constant □ In Episodes □

Yes □ No □ 4. Weakness in arms or legs. Constant □ In Episodes □

Yes □ No □ 5. Clumsiness of arms or legs. Constant □ In Episodes □

Yes □ No □ 6. Confusion of loss of consciousness. Constant □ In Episodes □

Yes □ No □ 7. Difficulty with speech. Constant □ In Episodes □

Yes □ No □ 8. Difficulty with swallowing. Constant □ In Episodes □

Yes □ No □ 9. Pain in the neck or shoulder. Constant □ In Episodes □

Yes □ No □ 10. Seasickness or car sickness. Constant □ In Episodes □