

DIZZINESS QUESTIONNAIRE

Patient's name: _____

Date: _____

Please help us to obtain your Dizziness history by printing and completing this form:

Dizziness Questionnaire

I. When you are "dizzy", do you experience any of the following sensations? Please read the entire list first. Then put an "x" in either the first box for YES, or the second box for NO to describe your feelings most accurately.

- | YES | NO | |
|--------------------------|--------------------------|-----------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Lightheadedness/swimming sensation in head. |
| <input type="checkbox"/> | <input type="checkbox"/> | Blacking out. |
| <input type="checkbox"/> | <input type="checkbox"/> | Tendency to fall: to the Right? Left? Forward? Backward? |
| <input type="checkbox"/> | <input type="checkbox"/> | Objects spinning or turning around you. |
| <input type="checkbox"/> | <input type="checkbox"/> | Sensation that you are turning or spinning inside, with outside objects remaining stationary. |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of balance when walking: Veering right? Veering left? |
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea or vomiting. |
| <input type="checkbox"/> | <input type="checkbox"/> | Pressure in the head. |

II. Please check a box for either YES or NO, and fill in the blank spaces.

- | YES | NO | |
|--------------------------|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | My dizziness is: Constant? In Attacks?
When did the dizziness first occur? _____
If in attacks: How often? _____
How long do they last? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is there any warning that an attack is about to start? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you completely free of dizziness between attacks? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does dizziness occur only in certain positions? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have trouble walking in the dark? |
| <input type="checkbox"/> | <input type="checkbox"/> | If dizzy, must you support yourself when standing? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you know of any possible cause of your dizziness?
What? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you know of anything that will:
Stop your dizziness, or make it better? |
| <input type="checkbox"/> | <input type="checkbox"/> | Make your dizziness worse? |
| <input type="checkbox"/> | <input type="checkbox"/> | Precipitate an attack? |
| <input type="checkbox"/> | <input type="checkbox"/> | Were you exposed to irritating fumes (paints, etc.) at the onset of dizziness? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any allergies? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did you ever injure your head or neck?
Were you unconscious? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use tobacco in any form? How much? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use alcohol? |

(Please scroll down and complete page 2 also)

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III. Do you have any of the following symptoms? Mark YES or NO, and if YES, circle ear involved.

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in hearing? Both ears Right Left When did this start? _____
<input type="checkbox"/>	<input type="checkbox"/>	Is it getting worse?
<input type="checkbox"/>	<input type="checkbox"/>	Noise in your ears? Both ears Right Left Describe the noise _____
<input type="checkbox"/>	<input type="checkbox"/>	Does the noise change with dizziness? How? _____
<input type="checkbox"/>	<input type="checkbox"/>	Does anything stop the noise or make it better?
<input type="checkbox"/>	<input type="checkbox"/>	Fullness/stuffiness in ears? Both ears Right Left
<input type="checkbox"/>	<input type="checkbox"/>	Does this change when you are dizzy?
<input type="checkbox"/>	<input type="checkbox"/>	Pain in your ears? Both ears Right Left
<input type="checkbox"/>	<input type="checkbox"/>	Discharge from your ears? Both ears Right Left
<input type="checkbox"/>	<input type="checkbox"/>	Have you had ear surgery? What type? _____

IV. Have you ever experienced any of the following symptoms? Put an "x" in the first box for YES or the second box for NO, and circle if "Constant" or "In Episodes".

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Double Vision Constant In Episodes
<input type="checkbox"/>	<input type="checkbox"/>	Numbness of face Constant In Episodes
<input type="checkbox"/>	<input type="checkbox"/>	Numbness of extremities Constant In Episodes
<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision or blindness Constant In Episodes
<input type="checkbox"/>	<input type="checkbox"/>	Weakness in arms or legs Constant In Episodes
<input type="checkbox"/>	<input type="checkbox"/>	Headache Constant In Episodes
<input type="checkbox"/>	<input type="checkbox"/>	Confusion/unconsciousness Constant In Episodes
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with speech Constant In Episodes
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with swallowing Constant In Episodes
<input type="checkbox"/>	<input type="checkbox"/>	Tingling around the mouth Constant In Episodes
<input type="checkbox"/>	<input type="checkbox"/>	Spots before the eyes Constant In Episodes

V. Please check box for either YES or NO.

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Do you get dizzy after exertion or overwork?
<input type="checkbox"/>	<input type="checkbox"/>	Did you get new glasses recently?
<input type="checkbox"/>	<input type="checkbox"/>	Do you tend to get upset easily?
<input type="checkbox"/>	<input type="checkbox"/>	Do you get dizzy when you have not eaten in a long time?
<input type="checkbox"/>	<input type="checkbox"/>	Is your dizziness connected with your menstrual period?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a neck injury?
<input type="checkbox"/>	<input type="checkbox"/>	Have you had blood work recently? What type? _____
<input type="checkbox"/>	<input type="checkbox"/>	When/where? _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you had a CT/MRI of the head/brain? When/where? _____
		What did it show? _____
		What treatment have you had for dizziness? _____