DIZZINESS QUESTIONNAIRE

Thank you for your cooperation in filling out this brief questionnaire.

Name:__________________________________________________       Date:___________________________

I.   When you are “dizzy” do you experience any of the following symptoms? (check yes or no)

1. Light-headedness or swimming sensation in the head?    □ Yes □ No
2. Blacking out or loss of consciousness?    □ Yes □ No
3. Tendency to fall? □ to the left? □ to the right? □ forward? □ backward?
4. Objects spinning or turning around you?    □ Yes □ No
5. Sensation that you are spinning or turning?    □ Yes □ No
6. Loss of balance while walking? □ veering to the left? □ veering to the right? □
7. Headache?    □ Yes □ No
8. Nausea or vomiting?    □ Yes □ No
9. Pressure in the head?    □ Yes □ No
10. Tingling in your fingers, toes or around your mouth?    □ Yes □ No

II. Please check yes or no and fill in the blanks answering all questions.

1. My dizziness is: □ Constant? □ In attacks or episodes?
2. When did the dizziness first occur?  __________________________________________
3. If in attacks:   How often do attacks occur?  _____________________________________________
                   How long do they last?  ____________________________________________
                   When was the first episode?  ________________________________
                   What was the duration of the shortest attack?  ________________________________
                   Do you have any warning that it is going to occur?    □ 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 any possible cause of your dizziness?    □ 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?    □ Yes □ No
     (e.g.: fatigue, exertion, hunger, menstrual period, stress, emotional upset, alcohol)
9. Were you exposed to any irritating fumes, paints, etc. at the onset of dizziness?    □ Yes □ No
III. Past medical history

1. Do you have a history of any of the following? Please check all that apply.
   - [ ] heart disease  
   - [ ] hypertension  
   - [ ] kidney disease  
   - [ ] thyroid disease  
   - [ ] migraine headaches  

2. Do you have any family history of any of the following? Please check all that apply.
   - [ ] ear disease  
   - [ ] neurological disease  
   - [ ] migraine headache  

3. Do you take any medicines regularly? If yes, please list: ________________________  
   [ ] Yes  [ ] No  
   ________________________________________________________________  

4. Are you allergic to any medications? If yes, please list: ________________________  
   [ ] Yes  [ ] No  
   ________________________________________________________________  

5. Have you ever suffered a serious head injury or been knocked unconscious?  
   [ ] Yes  [ ] No  

6. Do you use tobacco in any form?  
   ___________________________  
   [ ] Yes  [ ] No  
   How much? ____________________  
   For how long? ___________________  

IV. Do you have any of the following symptoms? Check yes or no and the ear involved.

1. Difficulty in hearing?  
   [ ] Yes  [ ] No  [ ] Both ears  [ ] Right ear  [ ] Left ear  [ ] Associated with Attack  
   Describe the noise: ___________________________________________________________________________  

2. Noise in your ears?  
   [ ] Yes  [ ] No  [ ] Both ears  [ ] Right ear  [ ] Left ear  [ ] Associated with Attack  
   Describe the noise: ___________________________________________________________________________  

3. Does the noise change with dizziness, and if so, how?  
   ___________________________  
   [ ] Yes  [ ] No  
   ________________________________________________________________  

4. Pain in your ears?  
   [ ] Yes  [ ] No  [ ] Both ears  [ ] Right ear  [ ] Left ear  [ ] Associated with Attack  

5. Fullness or stuffiness in your ears?  
   [ ] Yes  [ ] No  [ ] Both ears  [ ] Right ear  [ ] Left ear  [ ] Associated with Attack  

6. Discharge from your ears?  
   [ ] Yes  [ ] No  [ ] Both ears  [ ] Right ear  [ ] Left ear  [ ] Associated with Attack  

V. Have you experienced any of the following symptoms? Check yes or no and if constant or in episodes.

1. Double or blurred vision or blindness?  
   [ ] Yes  [ ] No  [ ] Constant  [ ] Episodes  

2. Numbness of face?  
   [ ] Yes  [ ] No  [ ] Constant  [ ] Episodes  

3. Numbness of arms and legs?  
   [ ] Yes  [ ] No  [ ] Constant  [ ] Episodes  

4. Weakness in arms or legs?  
   [ ] Yes  [ ] No  [ ] Constant  [ ] Episodes  

5. Clumsiness in arms or legs?  
   [ ] Yes  [ ] No  [ ] Constant  [ ] Episodes  

6. Confusion or loss of consciousness?  
   [ ] Yes  [ ] No  [ ] Constant  [ ] Episodes  

7. Difficulty of speech?  
   [ ] Yes  [ ] No  [ ] Constant  [ ] Episodes  

8. Difficulty with swallowing?  
   [ ] Yes  [ ] No  [ ] Constant  [ ] Episodes  

9. Pain in neck or shoulder?  
   [ ] Yes  [ ] No  [ ] Constant  [ ] Episodes