**Patient Name:** ______________________ **DOB:** ______________ **DATE:** ______________

# DIZZINESS QUESTIONNAIRE

**** Please use Blue or Black ink Only ****

**When you are experiencing "dizziness" do you also experience any of the following sensations listed below? Please read the entire list and answer each question by checking a YES or NO box. If required, please provide additional details.**

**Section I.**

| Yes | No | |
|---|---|---|
| ☐ | ☐ | 1. Lightheadedness? |
| ☐ | ☐ | 2. Swimming sensation in the head? |
| ☐ | ☐ | 3. Blacking out? |
| ☐ | ☐ | 4. Loss of consciousness? |
| ☐ | ☐ | 5. Tendency to fall: If Yes, circle each that applies: To the right? To the left? Forward? Backward? |
| ☐ | ☐ | 6. Do you ever feel as though objects are spinning or turning around you? |
| ☐ | ☐ | 7. Do you ever feel the sensation that you are turning or spinning inside, with outside objects remaining stationary? |
| ☐ | ☐ | 8. Do you experience loss of balance when walking: Veering to the **Right** or the **Left ?** |
| ☐ | ☐ | 9. Headaches? |
| ☐ | ☐ | 10. Nausea or vomiting? |
| ☐ | ☐ | 11. Pressure in the head? |

**Section II.**

| Yes | No | |
|---|---|---|
| ☐ | ☐ | 1. My dizziness is constant? |
| ☐ | ☐ | - or- occurs in attacks? |
| ☐ | ☐ | 2. When did your dizziness first occur? ______________________ |
| ☐ | ☐ | 3. If in attacks: How often? ______________________ |
| | | How long do the attacks last? ______________________ |
| ☐ | ☐ | Do you have any warning that the attack is about to occur? |
| ☐ | ☐ | 4. Are you completely free of dizziness between attacks? |
| ☐ | ☐ | 5. Does dizziness occur only in certain positions? |
| ☐ | ☐ | 6. Do you have trouble walking in the dark? |
| ☐ | ☐ | 7. When you are dizzy, do you need support to stand? |
| ☐ | ☐ | 8. Do you know of any possible cause for your dizziness? |
| | | List cause(s)? ______________________ |
| ☐ | ☐ | 9. Do you know of anything that will: |
| ☐ | ☐ | Stop your dizziness or make it better? ______________________ |
| ☐ | ☐ | Make your dizziness worse? ______________________ |
| ☐ | ☐ | Cause an attack? ______________________ |
| ☐ | ☐ | 10. Were you exposed to any irritating fumes, paints, etc., at the onset of dizziness? |
| ☐ | ☐ | 11. Do you have any allergies? ______________________ |
| ☐ | ☐ | 12. Have you ever injured your head? Explain: ______________________ |
| ☐ | ☐ | Were you unconscious? |

| Yes | No | |
|---|---|---|
| ☐ | ☐ | 13. Do you take any medications regularly? (i.e. tranquilizers, oral contraceptives, barbiturates, antibiotics). List medications ? ____________ |
| ☐ | ☐ | 14. Do you use tobacco in any form? What form and how often? ____________ |
| ☐ | ☐ | 15. Do you drink alcoholic beverages? How many glasses? ______ How often? ____________ |
| ☐ | ☐ | 16. Have you ever had ear surgery? What type surgery? ____________ When?____________ |

**III. Do you have any of the following symptoms?**

| | | | | | |
|---|---|---|---|---|---|
| ☐ | ☐ | 1. Difficulty hearing? | Both ears | Right | Left |
| | | When did this start? ____________ | | | |
| ☐ | ☐ | Is it worsening? | | | |
| ☐ | ☐ | 2. Noise in your ears? | Both ears | Right | Left |
| | | Describe the noise____________ | | | |
| ☐ | ☐ | Does the noise change with dizziness? If Yes describe the change? ____________ | | | |
| ☐ | ☐ | Does anything stop the noise or make it better? If Yes describe ____________ | | | |
| ☐ | ☐ | 3. Fullness or stuffiness in your ears? | Both ears | Right | Left |
| ☐ | ☐ | 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 |

**Section IV. Have you ever experienced any of the following symptoms?**
**Circle if "Constant" or if "In Episodes".**

| | | | | |
|---|---|---|---|---|
| ☐ | ☐ | 1. Double vision? | Constant | In Episodes |
| ☐ | ☐ | 2. Numbness of face or extremities? | Constant | In Episodes |
| ☐ | ☐ | 3. Blurred vision or blindness? | Constant | In Episodes |
| ☐ | ☐ | 4. Weakness in arms or legs? | Constant | In Episodes |
| ☐ | ☐ | 5. Clumsiness in arms or legs? | Constant | In Episodes |
| ☐ | ☐ | 6. Confusion or loss of consciousness? | Constant | In Episodes |
| ☐ | ☐ | 7. Difficulty with speech? | Constant | In Episodes |
| ☐ | ☐ | 8. Difficulty with swallowing? | Constant | In Episodes |
| ☐ | ☐ | 9. Tingling around the mouth? | Constant | In Episodes |
| ☐ | ☐ | 10. Do you see spots? | Constant | In Episodes |

**Section V.**

| | | |
|---|---|---|
| ☐ | ☐ | 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 your dizziness connected with your menstrual period? |
| ☐ | ☐ | 6. Have you ever had a neck injury? |