DIZZINESS QUESTIONNAIRE

NAME ____________________________________

DATE ______________________

I. Please answer the following questions by checking the YES or NO and filling the blank where appropriate.

YES	NO		
		1.	When did your dizziness first begin? ______________________________
☐	☐	2.	The dizziness is constant.
☐	☐	3.	The dizziness is in attacks.
☐	☐	4.	If in attacks, how often? ______________________________
			How long do they last? ______________________________
		5.	Do you experience:
☐	☐		a) Light headedness
☐	☐		b) Swimming sensation in the head
☐	☐		c) Black-out spells
☐	☐		d) Loss of consciousness
☐	☐		e) Objects spinning or turning about you
☐	☐		f) Sensation that you are spinning or turning, and that outside objects remain stationary
☐	☐		g) Loss of balance when walking Veer to the right ☐ Veer to the left ☐
☐	☐	6.	Will anything stop your dizziness or make it better?
			Explain ______________________________
☐	☐	7.	Will anything make your dizziness worse?
			Explain ______________________________
☐	☐	8.	Will anything bring on an attack?
			Explain ______________________________
☐	☐	9.	Can you tell when an attack is about to start?

YES	NO		
☐	☐	10.	Do changes in position make you dizzy?
☐	☐		Do you experience dizziness when looking up, such as getting something from a top shelf.
☐	☐	11.	Are you free of dizziness between attacks?
☐	☐	12.	When you are dizzy, can you stand unsupported?
☐	☐		Walk
☐	☐	13.	Difficulty hearing Both ears ☐ Right ear ☐ Left ear ☐
☐	☐	14.	Does your hearing get worse when you are dizzy? Both ears ☐ Right ear ☐ Left ear ☐
☐	☐	15.	Noise in your ears Both ears ☐ Right ear ☐ Left ear ☐
			Describe the noise. ____________________
☐	☐	16.	Does the noise change with the dizziness?
			If so, how? ____________________
☐	☐	17.	Fullness or stuffiness or blocked feeling in the ears Both ears ☐ Right ear ☐ Left ear ☐
☐	☐		Does this change when you are dizzy?
☐	☐	18.	Do you get nauseated when you are dizzy?
☐	☐	19.	Do you vomit when you are dizzy?
☐	☐	20.	Pain in your ears Both ears ☐ Right ear ☐ Left ear ☐
☐	☐	21.	Discharge from your ears Both ears ☐ Right ear ☐ Left ear ☐
☐	☐	22.	Do you have trouble walking in the dark?

YES	NO		
☐	☐	23.	Do you have any allergies?
☐	☐	24.	Did you every injure your head?
			Were you unconscious?
☐	☐	25.	Do you take any medication regularly?
			List ______________________________
☐	☐	26.	Do you use tobacco?
☐	☐	27.	How much alcohol do you drink a day? ______________________________
☐	☐	28.	Do you have or have you had:
☐	☐		a) Heart trouble
☐	☐		b) High blood pressure
☐	☐		c) A stroke
☐	☐		d) Diabetes
☐	☐		e) Kidney disease
☐	☐		f) Tyroid disease

II. Have you experienced any of the following symptoms? Please check either YES or NO and circle either CONSTANT or IN EPISODES:

☐	☐	1.	Headache	CONSTANT	IN EPISODES
☐	☐	2.	Pressure in head	CONSTANT	IN EPISODES
☐	☐	3.	Double vision	CONSTANT	IN EPISODES
☐	☐	4.	Numbness or tingling in face or extremities	CONSTANT	IN EPISODES
☐	☐	5.	Blindness or flashing lights	CONSTANT	IN EPISODES
☐	☐	6.	Weakness in arms or legs	CONSTANT	IN EPISODES
☐	☐	7.	Clumsiness in arms or legs	CONSTANT	IN EPISODES
☐	☐	8.	Confusion or loss of consciousness	CONSTANT	IN EPISODES
☐	☐	9.	Difficulty with speech	CONSTANT	IN EPISODES
☐	☐	10.	Difficulty with swallowing	CONSTANT	IN EPISODES