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Patient:________________________ Date:___________ Physician:__________________________

DIZZINESS QUESTIONNAIRE

1. When you are **"dizzy"** do you experience any of the following sensations? Please put an **"X"** in the first box for **YES** or the second box for **NO** to describe your feelings most accurately.

YES	NO	
☐	☐	1. Lightheadedness.
☐	☐	2. Swimming sensation in head.
☐	☐	3. Blacking out.
☐	☐	4. Loss of consciousness.
☐	☐	5. Tendency to fall: To the right?
☐	☐	To the left?
☐	☐	Forward?
☐	☐	Backward?
☐	☐	6. Objects spinning or turning around you.
☐	☐	7. Sensation that you are turning or spinning inside, with outside objects remaining stationary.
☐	☐	8. Loss of balance when walking: Veering to the right?
☐	☐	Veering to the left?
☐	☐	9. Headache.
☐	☐	10. Nausea or vomiting.
☐	☐	11. Pressure in the head.

2. Please check box for either **YES** or **NO** and fill in the blank spaces.

YES	NO	
☐	☐	1. Is your dizziness constant?
☐	☐	in attacks?
		2. When did dizziness first occur? ________________________________
		3. If in attacks: How often?________________________________
		How long?________________________________
☐	☐	Do you have any warning that the attack is about to start? What?______________
☐	☐	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, must you support yourself when standing?

YES	NO	
☐	☐	8. Do you know of any possible cause of your dizziness? What?__________
		9. Do you know of anything that will:
☐	☐	Stop your dizziness or make it better?
☐	☐	Make your dizziness worse?
☐	☐	Precipitate 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?
☐	☐	Were you unconscious?
☐	☐	13. Do you take any medications regularly? (i.e. tranquilizers, oral contraceptives, barbiturates, antibiotics.) What?__________
☐	☐	14. Do you use tobacco in any form? How much?__________
☐	☐	15. Do you use alcohol? How often?__________
☐	☐	16. Have you ever had ear surgery?

3. Do you have any of the following symptoms? Put an "X" in either the first box for **YES** or the second box for **NO** and circle ear involved.

YES	NO				
☐	☐	1. Difficulty in hearing?	Both ears	Right	Left
		When did this start?__________			
☐	☐	Is it getting worse?			
☐	☐	2. Noise in your ears?	Both ears	Right	Left
		Describe the noise__________			
☐	☐	Does noise change with dizziness? If so, how__________			
☐	☐	Does anything stop the noise or make it better?__________			
☐	☐	3. Fullness 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

4. Have you ever experienced any of the following symptoms? Put an "X" in either the first box for **YES** or the second box for **NO** and circle if **CONSTANT** or if in **EPISODES.**

YES	NO			
☐	☐	1. Double vision.	Constant	Episodes
☐	☐	2. Numbness of face or extremities.	Constant	Episodes
☐	☐	3. Blurred Vision or blindness.	Constant	Episodes
☐	☐	4. Weakness in arms or legs.	Constant	Episodes
☐	☐	5. Clumsiness in arms or legs.	Constant	Episodes
☐	☐	6. Confusion or loss of consciousness.	Constant	Episodes
☐	☐	7. Difficulty with speech.	Constant	Episodes
☐	☐	8. Difficulty with swallowing.	Constant	Episodes
☐	☐	9. Tingling around the mouth.	Constant	Episodes
☐	☐	10.Spots before eyes.	Constant	Episodes

5. Please check box for either **YES** or **NO.**

YES	NO	
☐	☐	1. Do you get dizzy after physical 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 period of time?
☐	☐	5. Is your dizziness connected with your menstrual period?
☐	☐	6. Have you every had a neck injury?