

DIZZINESS QUESTIONNAIRE

NAME _____ DATE _____
FIRST MIDDLE LAST

PLEASE ANSWER ALL QUESTIONS

I. When you are “dizzy” do you experience any of the following sensations? PLEASE READ THE ENTIRE LIST FIRST. Then check either 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 the 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.
- 11. Vomiting.
- 12. Pressure in the head.
- 13. Other: Explain _____

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

YES NO

- 1. When did dizziness first occur? _____
- 2. Are you dizzy all the time?
- 3. Does your dizziness occur in attacks?
If in attacks: How often? _____
How long do they last? _____
- 4. Can you tell when an attack is about to start?
If so, how? _____
- 5. Are you completely free of dizziness between attacks?
- 6. Does change of position make you dizzy?
- 7. Do you have trouble walking in the dark?
- 8. When you are dizzy, can you stand up unsupported?
- 9. Do you know of any possible cause of your dizziness?
What? _____
- 10. Do you know of anything that will:
 Stop your dizziness or make it better? What? _____
 Make your dizziness worse? What? _____
 Bring on an attack? What? _____

- | | | |
|--------------------------|--------------------------|---|
| YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Is there any relationship between eating and your dizziness?
If so, what? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 12. Do you think you eat a lot of animal fat? |
| <input type="checkbox"/> | <input type="checkbox"/> | 13. Were you exposed to any irritating fumes, paints, etc. at the onset of your dizziness?
What? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you have any allergies? What? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 15. Did you ever injure your head? When? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Were you unconscious? How long? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 16. Do you take any medications regularly?
What? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 17. Do you use tobacco in any form?
How much? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 18. Do you think you are under any unusual strain or tension? |
| <input type="checkbox"/> | <input type="checkbox"/> | 19. Has anyone in your family had similar dizziness?
Who? _____ |

III. Do you have any of the following symptoms? Check either YES or NO and CIRCLE ear involved.

- | | | | | |
|--------------------------|--------------------------|---|-----------|------------|
| YES | NO | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Difficulty in hearing? | Both ears | Right Left |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Noise in your ears? | Both ears | Right Left |
| <input type="checkbox"/> | <input type="checkbox"/> | Describe the noise _____ | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Does noise change with dizziness? If so, how? _____ | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Fullness, stuffiness or pressure in your ears? | Both ears | Right Left |
| <input type="checkbox"/> | <input type="checkbox"/> | Does this change when you are dizzy? | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Pain in your ears? | Both ears | Right Left |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Discharge from your ears? | Both ears | Right Left |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Have you ever been exposed to loud noise? | | |
| <input type="checkbox"/> | <input type="checkbox"/> | When? _____ How Long? _____ | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Did you wear sound protection? | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Has anyone in your family had a hearing problem?
Who? _____ | | |

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

- | | | | |
|--------------------------|--------------------------|------------------------------------|----------------------|
| YES | NO | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Double vision | Constant In episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Blurred vision | Constant In episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Blindness | Constant In episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Numbness of your face | Constant In episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Numbness of your arms or legs | Constant In episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Weakness in your arms or legs | Constant In episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Clumsiness in your arms or legs | Constant In episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Mental confusion | Constant In episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Loss of consciousness | Constant In episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Difficulty with speech | Constant In episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Difficulty with swallowing | Constant In episodes |

HAVE YOU ANSWERED EACH QUESTION EITHER YES OR NO?