

## DIZZINESS QUESTIONNAIRE

Name \_\_\_\_\_ Date \_\_\_\_\_

1. When you are "dizzy," do you experience any of the following sensations? Circle Yes or No to describe your feelings most accurately.

- Yes No 1. Lightheadedness.
- Yes No 2. Swimming sensation in the head.
- Yes No 3. Blacking out.
- Yes No 4. Loss of consciousness.
- Yes No 5. Tendency to fall:
  - To the right?
  - To the left?
  - Forward?
  - Backward?
- Yes No 6. Objects spinning or turning around you.
- Yes No 7. Sensation that you are turning or spinning inside.
- Yes No 8. Loss of balance when walking:
  - Veering to the right?
  - Veering to the left?
- Yes No 9. Headache. sometimes? \_\_\_\_\_ constant? \_\_\_\_\_
- Yes No 10. Nausea or vomiting.
- Yes No 11. Pressure in the head.

2. Please circle Yes or No and fill in the blank spaces.

- Yes No 1. My dizziness is constant.
- Yes No 2. My dizziness is constant only during an attack.
- 3. When did dizziness first occur? \_\_\_\_\_
- 4. How often do your attacks occur? \_\_\_\_\_
- 5. How long do your attacks last? \_\_\_\_\_
- Yes No 6. Do you have any warning that an attack is about to start?
- Yes No 7. Are you completely free of dizziness between attacks?
- Yes No 8. Does dizziness occur only in certain positions?
- Yes No 9. Do you have trouble walking in the dark?
- Yes No 10. When you are dizzy, must you support yourself when standing?
- Yes No 11. Do you know of any possible cause of your dizziness? \_\_\_\_\_
- 12. Do you know of anything that will:
  - Stop your dizziness or make it better? \_\_\_\_\_
  - Make your dizziness worse? \_\_\_\_\_
  - Precipitate an attack? \_\_\_\_\_

- Yes No 13. Are you exposed to any irritating fumes, paints, etc., at the onset of dizziness? \_\_\_\_\_
- Yes No 14. Did you ever injure your head? \_\_\_\_\_
- Yes No 15. Do you get dizzy after exertion or overwork?
- Yes No 16. Did you get new glasses recently?
- Yes No 17. Do you get dizzy when you have not eaten for a long time?
- Yes No 18. Is your dizziness connected to your menstrual period?

**3. Do you have any of the following symptoms? Circle Yes or No and the ear involved.**

- |     |    |   |           |       |      |
|-----|----|---|-----------|-------|------|
| Yes | No | 1. Difficulty in hearing?                             | Both ears | Right | Left |
|     |    | When did this start? _____                            |           |       |      |
| Yes | No | Is it getting worse?                                  |           |       |      |
| Yes | No | 2. Noise in your ears?                                | Both ears | Right | Left |
|     |    | Describe the noise _____                              |           |       |      |
|     |    | Does noise change with dizziness? If so, how? _____   |           |       |      |
| Yes | No | Does anything stop the noise or make it better? _____ |           |       |      |
| Yes | No | 3. Fullness or stuffiness in your ears?               | Both ears | Right | Left |
| Yes | No | Does this change when you are dizzy?                  |           |       |      |

**4. Have you recently experienced any of the following symptoms? Circle Yes or No and if Constant or if in Episodes.**

- |     |    |  |          |             |
|-----|----|--|----------|-------------|
| Yes | No | 1. Double vision.                      | Constant | In Episodes |
| Yes | No | 2. Numbness of face or extremities.    | Constant | In Episodes |
| Yes | No | 3. Blurred vision or spots.            | Constant | In Episodes |
| Yes | No | 4. Weakness in arms or legs.           | Constant | In Episodes |
| Yes | No | 5. Clumsiness in arms or legs.         | Constant | In Episodes |
| Yes | No | 6. Confusion or loss of consciousness. | Constant | In Episodes |
| Yes | No | 7. Tingling around the mouth.          | Constant | In Episodes |