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DIZZY QUESTIONNAIRE

Name: ______________________ Date: ______________________

I) When you are "dizzy" do you experience any of the following sensations?
(Please read the entire list first, then check yes or no **to describe your feelings most accurately.**)

Yes	No	
☐	☐	1. Light-headedness or swimming sensation in the head?
☐	☐	2. Blacking out or loss of consciousness?
☐	☐	3. Tendency to fall: To the right ?
☐	☐	To the left?
☐	☐	Forward?
☐	☐	Backward?
☐	☐	4. Objects spinning or swimming around you?
☐	☐	5. Sensation that you are turning or spinning inside with outside objects remaining stationary?
☐	☐	6. Sensation of the environment moving up and down while you walk?
☐	☐	7. Loss of balance when walking: Veering to the right?
☐	☐	Veering to the left?
☐	☐	8. Headache?
☐	☐	9. Nausea/vomiting?
☐	☐	10. Pressure in the head?
☐	☐	11. Palpitations, perspiration, shortness of breath, or a feeling of panic?

II) Please check yes or no and fill in the blanks. Please answer all questions.

Yes	No	
☐	☐	1. My dizziness is: Constant.
☐	☐	In attacks.
		2. When did dizziness first occur? ______________________
		3. If in attacks: How often? ______________________
		How long do they last? ______________________
		When was last attack? ______________________
☐	☐	Do you have any warning that the attack is about to start?
☐	☐	Do they occur at any particular time of day or night?
☐	☐	Are you completely free of dizziness between attacks?

Yes	No	
☐	☐	4. Does change of position make you dizzy?
☐	☐	5. Do you have trouble walking in the dark?
☐	☐	6. When you are dizzy, must you support yourself when standing?
☐	☐	7. List the possible causes of dizziness?____________________
		8. Do you know of anything that will:
☐	☐	Stop your dizziness or make it better?____________________
☐	☐	Make your dizziness worse?____________________
☐	☐	Precipitate an attack? (eg: Fatigue, exertion, hunger, stress, emotional upset or menstrual period) ____________________
☐	☐	9. Were you exposed to any irritating fumes, paints, etc. at the onset of dizziness?
☐	☐	10. Please list any medications you are allergic to ____________________
☐	☐	11. If you ever injured your head, were you unconscious?
		12. Please list any medications you take regularly ____________________
☐	☐	13. Do you use tobacco in any form (please list) ____________________
		How much?____________________

III) Do you have any of the following symptoms? please check yes or no and which ear is involved.

Yes	No		Right	Left	Both
☐	☐	1. Difficulty hearing?	☐	☐	☐
☐	☐	2. Noise in your ears?	☐	☐	☐
		Describe the noise ____________________			
		Does the noise change with dizziness? If so, how? ____________________			
☐	☐	3. Fullness or stuffiness?	☐	☐	☐
☐	☐	4. Pain in your ears?	☐	☐	☐
☐	☐	5. Discharge from your ears	☐	☐	☐

IV) Have you experienced any of the following symptoms? Please check yes or no and if constant or in episodes.

Yes	No		Constant	In Episodes
☐	☐	1. Double vision, blurred vision or blindness.	☐	☐
☐	☐	2. Numbness of face.	☐	☐
☐	☐	3. Numbness of arms or legs.	☐	☐
☐	☐	4. Weakness of arms or legs.	☐	☐
☐	☐	5. Clumsiness of arms or legs.	☐	☐
☐	☐	6. Confusion or loss of consciousness.	☐	☐
☐	☐	7. Difficulty with speech.	☐	☐
☐	☐	8. Difficulty with swallowing.	☐	☐
☐	☐	9. Pain in the neck or shoulder.	☐	☐
☐	☐	10. Seasickness or car sickness.	☐	☐

Thank You