Dizziness Questionnaire

Patient Name:_____ DOB:_____ Sex: _____ Date:_____

The following questions refer to your feeling of dizziness. Please answer them as "Yes" or "No" and fill in all blanks.

Please describe in your own words, the sensation you feel without using the word "dizzy."

_____
_____
_____

Do you ever have any of the following sensations?

Yes.....Spinning in Circles ..... No
Yes.....Falling to one side ..... No
Yes.....World spinning around you ..... No

I. The following refer to a typical dizzy spell:

Yes.....Do the dizzy spells come in attacks?..... No
How often?_____
How long?_____
Date of first spell? _____
Yes.....Are you free from dizziness between attacks? ..... No
Yes.....Does your hearing change with an attack?..... No
Yes.....Are you dizzy mainly when you sit or stand up quickly?..... No
Yes.....Are you more dizzy in certain positions? ..... No
Which position?_____
Yes.....Are you nauseated during an attack? ..... No
Yes.....Are you sensitive to light when you are dizzy? ..... No
Yes.....Are you dizzy even when lying down?..... No
Yes.....Have you had a recent cold or flu preceding recent dizzy spells?. No
Yes.....Have you had fullness, pressure or ringing in your ears? ..... No
Yes.....Have you had pain or discharge in your ear of recent onset?..... No
Yes.....Have you had trouble walking in the dark?..... No
Yes.....Are you better if you sit or lie perfectly still? ..... No

II. The following refer to other sensations you may have:

Yes.....Do you black out or faint when dizzy? ..... No

Have you had:

Yes.....Severe or recurrent headaches? ..... No
Yes.....Light sensitivity or nausea with a headache ..... No
Yes.....Any double or blurry vision?..... No
Yes.....Numbness in your face or extremities? ..... No
Yes.....weakness or clumsiness in arms, legs? ..... No
Yes.....Slurred or difficult speech? ..... No
Yes.....Difficulty swallowing? ..... No
Yes.....Tingling around your mouth? ..... No
Yes.....Spots before your eyes? ..... No
Yes.....Jerking of arms or legs?..... No
Yes.....Seizures? ..... No
Yes.....Confusion or memory loss? ..... No
Yes.....Recent head trauma? ..... No
(if yes, please explain)_____

III. The following refer to your hearing. Indicate which side has been affected:

Yes.....Difficulty hearing in one ear? .....Left.....Right..... Both ..... No
Yes.....Ringing in one ear?.....Left.....Right..... Both ..... No
Yes.....Fulness in one ear? .....Left.....Right..... Both ..... No
Yes.....Loud sounds make you dizzy?...Left.....Right..... Both ..... No
Yes.....Change in hearing when dizzy? How?_____..... No

Have you had any of the following?
Yes.....Pain in ears? .....Left..... Right..... Both ..... No
Yes.....Discharge from ears?.....Left..... Right..... Both ..... No
Yes.....Hearing change?..... .... No
Better.....Left..... Right..... Both ..... No
Worse.....Left..... Right..... Both ..... No
Yes.....Exposure to loud noises?..... .... No
Yes.....Previous ear infections?..... .... No
Yes.....Previous ear surgery?..... .... No
What?_____
Yes.....Family history of deafness? .... No

IV. The following refer to habits and lifestyle:

Yes.....Is there added stress to your life recently? ..... No
Yes.....Are you dizzy or unsteady constantly? ..... No
Is your dizziness related to:
Yes.....Moments of stress?..... No
Yes.....Menstrual period? ..... No
Yes.....Overwork or exertion?..... No
Yes.....Do you feel lightheaded or have a swimming sensation
when you are dizzy? ..... No
Yes.....Do you find yourself breathing faster or deeper when excited
or dizzy?..... No
Yes.....Did you recently change eyeglasses? ..... No
Yes.....Have you ever had weakness or faintness a few hours
after eating? ..... No
Yes.....Do you drink coffee? How much?_____..... No
Yes.....Do you drink tea? How much_____ ..... No
Yes.....Do you drink soft drinks? How much?_____ .... No
Yes.....Do you drink alcohol? How much? _____ ..... No
Yes.....Do you smoke? What?_____ How much?_____ .... No

Do you have anything else to tell us about your particular problem which we have not asked you on this questionnaire?_____
_____
_____
_____
_____