

DIZZINESS QUESTIONNAIRE

NAME: _____ DATE: _____

PLEASE ANSWER ALL QUESTIONS!

When you are dizzy, do you experience any of the following sensations?
Please check either YES or NO.

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, 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 |

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

YES NO

- | | | | |
|-------|-------|-----|---|
| _____ | _____ | 1. | My dizziness is constant. |
| _____ | _____ | 2. | My dizziness is in attacks |
| | | | How often do the attacks occur? _____ |
| | | | How long do the attacks last? _____ |
| _____ | _____ | 3. | Can you tell when an attack is about to start? |
| _____ | _____ | 4. | Are you completely free of dizziness between attacks? |
| _____ | _____ | 5. | Does change of position make you dizzy? |
| _____ | _____ | 6. | Do you have trouble walking in the dark? |
| _____ | _____ | 7. | When you are dizzy, can you stand unsupported? |
| _____ | _____ | 8. | Do you know of any possible cause for your dizziness? |
| | | | If so, what? _____ |
| _____ | _____ | 9. | Do you know of anything that will stop or improve your dizziness? |
| | | | If so, what? _____ |
| _____ | _____ | 10. | Do you know of anything that will make your dizziness worse? |
| | | | If so, what? _____ |

YES NO

- _____ 11. Do you know of anything that will precipitate an attack of dizziness?
If so, what? _____
- _____ 12. Have you been exposed to any irritating chemical fumes, paints, etc?
If so, what? _____
- _____ 13. Do you have allergies, hay fever, asthma, eczema, or food intolerances?
If so, what treatment have you received? _____
- _____ 14. Have you ever injured your head?
- _____ 15. Have you ever been unconscious?
- _____ 16. Do you now, or have you ever had problems with drug abuse?

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

YES NO

- | | | | | | | |
|-------|-------|----|---------------------------------------|-----------|-------|------|
| _____ | _____ | 1. | Difficulty hearing? | Both ears | Right | Left |
| _____ | _____ | 2. | Noise in your ears? | Both ears | Right | Left |
| _____ | _____ | | Describe the noise. _____ | | | |
| _____ | _____ | 3. | Fullness or stuffiness in your ears? | | | |
| | | | | Both ears | Right | Left |
| _____ | _____ | 4. | Pain in your ears? | Both ears | Right | Left |
| _____ | _____ | 5. | Discharge or drainage from your ears? | | | |
| | | | | Both ears | Right | Left |

Have you experienced any of the following symptoms?
Check either YES or NO, and circle either CONSTANT or IN EPISODES.

YES NO

- | | | | | | |
|-------|-------|----|-------------------------------------|----------|-------------|
| _____ | _____ | 1. | Double vision | Constant | In Episodes |
| _____ | _____ | 2. | Numbness of face or extremities. | Constant | In Episodes |
| _____ | _____ | 3. | Blurred vision or blindness. | Constant | In Episodes |
| _____ | _____ | 4. | Weakness in arms or legs. | Constant | In Episodes |
| _____ | _____ | 5. | Clumsiness in arms or legs. | Constant | In Episodes |
| _____ | _____ | 6. | Confusion or loss of consciousness. | Constant | In Episodes |
| _____ | _____ | 7. | Difficulty with speech. | Constant | In Episodes |
| _____ | _____ | 8. | Difficulty with swallowing. | Constant | In Episodes |

Are there any family members with hearing disorders? _____

Are there any family members with diabetes? ___ heart disease? ___ hardening of the arteries?
___, thyroid disorder? _____.

Do you fall? _____

Have you every had cataract surgery? _____

Do you have cataracts now? _____