

## Dizziness Questionnaire

Date  Patient Name  DOB  Chart #

**A) When you are dizzy do you experience any of the following sensations?**

Please describe your feelings most accurately by placing a check in the box for YES or NO.

Yes No

- Lightheadedness?
- Swimming sensation in the head?
- Blacking out?
- Loss of consciousness?
- Tendency to fall: to the right?
- to the left?
- forward?
- backward?
- Objects spinning or turning around you?
- Sensation that you are turning or spinning inside, with outside objects remaining stationary?
- Loss of balance when walking: veering to the right?
- veering to the left?
- Headache?
- Nausea or vomiting?
- Pressure in the head?
- Is your dizziness constant?
- Is your dizziness in attacks?
- When did the dizziness first occur?
- If in attacks: How often?
- How long do they last?
- Do you have any warning that the attack is about to happen?
- Are you completely free of dizziness between attacks?
- Does dizziness occur only in certain positions?
- Do you have trouble walking in the dark?
- When you are dizzy, must you support yourself when standing?
- Do you know of any possible cause of your dizziness?
- If so explain
- Do you know of anything that will: stop your dizziness or make it better?
- make your dizziness worse?
- precipitate an attack?
- Were you exposed to any irritating fumes, paints, etc., at the onset of your dizziness?
- Do you have any allergies?
- Have you ever injured your head?
- If so, were you unconscious?
- Do you take any medications regularly? If so, what
- Do you use tobacco in any form? If so, how much
- Do you drink alcohol?
- Have you ever had ear surgery?

**B) Do you have any of the following symptoms?**

Place a check in the box for YES or NO and circle the ear involved.

Yes No

<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in hearing?	Both ears <input type="checkbox"/>	Right <input type="checkbox"/>	Left <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	When did it start?	<input type="text"/>		
<input type="checkbox"/>	<input type="checkbox"/>	Is it getting worse?	<input type="text"/>		
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in hearing?	Both ears <input type="checkbox"/>	Right <input type="checkbox"/>	Left <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Describe the noise	<input type="text"/>		
<input type="checkbox"/>	<input type="checkbox"/>	Does the noise change with the dizziness? If so, explain	<input type="text"/>		
<input type="checkbox"/>	<input type="checkbox"/>	Does anything stop the noise or make it better?	<input type="text"/>		
<input type="checkbox"/>	<input type="checkbox"/>	Is there fullness or stuffiness in your ears?	Both ears <input type="checkbox"/>	Right <input type="checkbox"/>	Left <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	If so, does this change when you are dizzy?	<input type="text"/>		
<input type="checkbox"/>	<input type="checkbox"/>	Is there pain in your ears?	Both ears <input type="checkbox"/>	Right <input type="checkbox"/>	Left <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Discharge from your ears?	Both ears <input type="checkbox"/>	Right <input type="checkbox"/>	Left <input type="checkbox"/>

**C) Have you ever experienced any of the following symptoms?**

Place a check in the box for YES or NO and circle if constant or in episodes.

Yes No

<input type="checkbox"/>	<input type="checkbox"/>	Double vision?	Constant <input type="checkbox"/>	Episodes <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Numbness of face or extremities?	Constant <input type="checkbox"/>	Episodes <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision or blindness?	Constant <input type="checkbox"/>	Episodes <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Weakness in arms or legs?	Constant <input type="checkbox"/>	Episodes <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Clumsiness in arms or legs?	Constant <input type="checkbox"/>	Episodes <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Confusion or loss of consciousness?	Constant <input type="checkbox"/>	Episodes <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with speech?	Constant <input type="checkbox"/>	Episodes <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with swallowing?	Constant <input type="checkbox"/>	Episodes <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Tingling around the mouth?	Constant <input type="checkbox"/>	Episodes <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Spots before your eyes?	Constant <input type="checkbox"/>	Episodes <input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	Do you get dizzy after exertion or overwork?		
<input type="checkbox"/>	<input type="checkbox"/>	Did you get new glasses recently?		
<input type="checkbox"/>	<input type="checkbox"/>	Do you tend to get upset easily?		
<input type="checkbox"/>	<input type="checkbox"/>	Do you get dizzy when you have not eaten for a long time?		
<input type="checkbox"/>	<input type="checkbox"/>	Is your dizziness connected with your menstrual period?		
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a neck injury?		

**D) Please let us know of anything else that you feel could help, that we have not asked you.**

Patient Name

Chart #