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DIZZINESS QUESTIONNAIRE

Name _____ Date _____

I When you are "dizzy" do you experience any of the following sensations? *Please read the entire list first.* Then circle (yes) or (no) TO DESCRIBE YOUR FEELINGS MOST ACCURATELY.

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

II Please Circle (yes) or (no) and fill in the blank spaces. **Answer all questions.**

1. My dizziness is:

Yes No Constant?
Yes No In attacks?

2. When did dizziness first occur? _____
3. If in attacks: How often? _____
How long do they last? _____
When was last attack? _____

Yes No Do you have any warning that the attack is about to start?
Yes No Do they occur at any particular time of day or night?
Yes No Are you completely free of dizziness between attacks?
Yes No 4. Does change of position make you dizzy?
Yes No 5. Do you have trouble walking in the dark?
Yes No 6. When you are dizzy, must you support yourself when standing?

(Please turn page and finish questionnaire.)

Yes No 7. Do you know of any possible cause of your dizziness? What? _____

8. Do you know of anything that will:

Yes No Stop your dizziness or make it better? _____

Yes No Make your dizziness worse? _____

Yes No Precipitate an attack? (Fatigue? Exertion? Hunger? Menstrual Period? Stress? Emotional Upset?)

Yes No 9. Were you exposed to any irritating fumes, paints, etc., at the onset of dizziness?

10. **If you are allergic** to any medications, please list: _____

_____

Yes No 11. If you ever injured your head, were you unconscious?

12. **If you take any medications** regularly, for any reason, please list: _____

_____

Yes No 13. Do you use tobacco in any form? _____ How much? _____

III Do you have any of the following symptoms? Please circle (yes) or (no) and circle (ear) involved.

Yes No 1. Difficulty in hearing? Both ears Right Left

Yes No 2. Noise in your ears? Both ears Right Left

Describe the noise _____

Yes No Does noise change with dizziness? If so, how? _____

_____

Yes No 3. Fullness or stuffiness in your ears? Both ears Right Left

Yes No 4. Pain in your ears? Both ears Right Left

Yes No 5. Discharge from your ears? Both ears Right Left

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

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