DIZZINESS QUESTIONNAIRE

NAME: _____ DATE: _____

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

1. Lightheadedness	**YES**	**NO**
2. Can't define easily	**YES**	**NO**
3. Head pain or pressure	**YES**	**NO**
4. Swimming sensation	**YES**	**NO**
5. Nausea and vomiting	**YES**	**NO**
6. Ear pressure – pain	**YES**	**NO**
7. Ear noise (before/during/after) LEFT/RIGHT	**YES**	**NO**
8. Objects spin around you	**YES**	**NO**
9. You are spinning around objects	**YES**	**NO**
10. Tendency to fall when walking (to the right, left, forward, backward)	**YES**	**NO**
11. Loss of balance (veer to left/right)	**YES**	**NO**
12. Loss of balance	**YES**	**NO**
13. Blacking out or loss of consciousness	**YES**	**NO**

II. <u>Please circle the best answer.</u>

1. Was onset of your dizziness	**SUDDEN**	**DELAYED**
2. My dizziness is	**CONSTANT**	**ATTACKS**
3. If in attacks, how often?	**(Each Hr., DAY, WEEK, ETC.)**	
How long do they last?	**SECONDS, MINUTES, HOURS, DAYS**	
Do you have a warning that an attack is about to start?	**YES**	**NO**
4. Are you completely free of dizziness between attacks?	**YES**	**NO**
5. Does change of position make you dizzy?	**YES**	**NO**
6. Do you have trouble walking in the dark?	**YES**	**NO**
7. When you are dizzy, must you support yourself when standing?	**YES**	**NO**
8. Do you know of anything that will stop your dizziness or make it better?	**YES**	**NO**
9 a. Were you exposed to any irritating fumes, paints, etc. at the onset of the dizziness?	**YES**	**NO**
9b. Where you exposed to virus, flu, or cold?	**YES**	**NO**
10. History of whiplash injury or neck injury?	**YES**	**NO**
11. Do you have any allergies?	**YES**	**NO**
12. Did you ever injure your head?	**YES**	**NO**
13. Do you take any medications regularly?	**YES**	**NO**
What?_____		
14. Do you use tobacco in any form?	**YES**	**NO**
Alcohol? _____How much?_____		
15. Is hearing loss associated with this problem? RIGHT/LEFT (Before/During/After)	**YES**	**NO**
16. Does eating a meal or not eating affect this problem?	**YES**	**NO**
17. Can you tell if an attack is coming on?	**YES**	**NO**

III. <u>Do you have any of the following symptoms? (</u>Please circle YES or NO and circle if Constant or In Episodes)

1. Double vision (Constant or In Episodes)	**YES**	**NO**
2. Numbness of face or extremities (Constant or In Episodes)	**YES**	**NO**
3. Blurred vision or blindness (Constant or In Episodes)	**YES**	**NO**
4. Weakness in arms or legs (Constant or In Episodes)	**YES**	**NO**
5. Clumsiness in arms or legs (Constant or In Episodes)	**YES**	**NO**
6. Confusion or loss of consciousness (Constant or In Episodes)	**YES**	**NO**
7. Difficulty with speech (Constant or In Episodes)	**YES**	**NO**
8. Difficulty with swallowing (Constant or In Episodes)	**YES**	**NO**