DIZZINESS QUESTIONNAIRE

***Patients fill out side one only**

NAME: _____ **DOB:** _____ **DATE:** _____

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

1. Light-headedness or swimming sensation in the head	**□ YES**	**□ NO**
2. Trouble focusing or can't define easily	**□ YES**	**□ NO**
3. Head pain or pressure	**□ YES**	**□ NO**
4. Nausea and/or vomiting	**□ YES**	**□ NO**
5. Ear pressure – pain	**□ YES**	**□ NO**
6. Ear noise	**□ YES**	**□ NO**
□ Before □ During □ After □ LEFT □ RIGHT		
7. Objects spinning or turning around you	**□ YES**	**□ NO**
8. Sensation that you are spinning or turning	**□ YES**	**□ NO**
9. Tendency to fall when walking	**□ YES**	**□ NO**
□ to the right □ to the left □ forward □ backward		
10. Loss of balance while walking	**□ YES**	**□ NO**
□ veer to left □ veer to right		
11. Blacking out or loss of consciousness	**□ YES**	**□ NO**

II. Please check the best answer.

1. Was onset of your dizziness	**□ SUDDEN**	**□ DELAYED**
2. My dizziness is	**□ CONSTANT**	**□ATTACKS**
3. If in attacks, how often? □ Each Hr □ DAY □ WEEK □_____		
How long do they last? □ SECONDS □ MINUTES □ HOURS □ DAYS		
4. Do you have a warning that an attack is about to start?	**□ YES**	**□ NO**
5. 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 At the onset of the dizziness		
a. Were you exposed to any irritating fumes, paints, etc?	**□ YES**	**□ NO**
b. Where you exposed to virus, flu, or cold?	**□ YES**	**□ NO**
10. Do you have any 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?_____ (See Med list)_____		
14. Do you use tobacco in any form?	**□ YES**	**□ NO**
15. Do you use Alcohol?	**□ YES**	**□ NO**
How much? □ Occasionally □ Frequently		
16. Is hearing loss associated with this problem?	**□ YES**	**□ NO**
□ Before □ During □ After □ LEFT □ RIGHT		
17. Does eating a meal or not eating affect this problem?	**□ YES**	**□ NO**
18. Can you tell if an attack is coming on?	**□ YES**	**□ NO**

III. Do you have any of the following symptoms? (Please check 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**