DIZZINESS QUESTIONNAIRE

Patient: **Date:**

A. When you are "dizzy", do you experience any of the following sensations?

YES	NO	
☐	☐	1. Lightheadedness?
☐	☐	2. Swimming sensation in the head?
☐	☐	3. Blacking out?
☐	☐	4. Loss of consciousness or near loss of consciousness?

B. Have you ever experienced any of the following?

YES	NO	
☐	☐	1. Objects spinning or turning around you?
☐	☐	2. Sensation that you are turning or spinning inside, with outside objects remaining stationary?
☐	☐	3. Loss of balance when walking: veering to the right?
☐	☐	veering to the left?
☐	☐	4. Tendency to fall: to the right?
☐	☐	to the left?
☐	☐	forward?
☐	☐	backward?
☐	☐	5. Trouble walking in the dark?
☐	☐	6. When you are dizzy, must you support yourself when standing?
☐	☐	7. Headache?
☐	☐	8. Nausea, vomiting or sweating?
☐	☐	9. Pressure in the head?

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

YES	NO	
☐	☐	1. Is your dizziness constant?
☐	☐	in attacks?
		2. When did the dizziness first occur? ____________
		3. How often do you have attacks? ____________ How long do they last? ____________
☐	☐	4. Do you have any warning the attack is about to start? What kind of warning? ____________
☐	☐	5. Are you completely free of dizziness between attacks?
☐	☐	6. Do you know of any possible cause of your dizziness? ____________
		7. Do you know of anything that will:
☐	☐	Stop your dizziness or make it better? ____________
☐	☐	Make your dizziness worse? ____________
☐	☐	Precipitate an attack? ____________

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

YES	NO	
☐	☐	1. Were you exposed to any irritating fumes, paints, etc, at the onset of dizziness? ____________
☐	☐	2. Do you take any medications regularly (tranquilizers, oral contraceptives, barbiturates, diuretics, antibiotics etc.) What do you take? ____________
☐	☐	3. Do you get dizzy after exertion or overwork?
☐	☐	4. Did you get new glasses recently?

YES	NO	
☐	☐	5. Do you tend to get upset easily?
☐	☐	6. Do you get dizzy when you have not eaten for a long time?
☐	☐	7. Is your dizziness connected with your menstrual period?
☐	☐	8. Have you ever had a neck injury?

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

YES	NO	
☐	☐	1. Does your dizziness occur only in certain positions? ______
☐	☐	2. Do you have any allergies? ______
☐	☐	3. Do you experience migraine headaches?
☐	☐	4. Did you ever injure your head? When? ______
☐	☐	Were you unconscious?
☐	☐	5. Do you use tobacco in any form? How much? ______
☐	☐	6. Do you use alcohol? How much? ______
☐	☐	7. Have you ever had ear surgery? Why? ______

F. Do you have any of the following symptoms? Please indicate which ear(s).

YES	NO		BOTH	RIGHT	LEFT
☐	☐	1. Difficulty in hearing?	☐	☐	☐
		When did this start? ______			
☐	☐	Is it getting worse?			
☐	☐	2. Noise in your ears?	☐	☐	☐
		Describe the noise: ______			
☐	☐	Does the noise change with dizziness?			
		How? ______			
☐	☐	3. Fullness/stuffiness in your ears?	☐	☐	☐
☐	☐	Does this feeling change with dizziness?			
		How? ______			
☐	☐	4. Pain in your ears?	☐	☐	☐
☐	☐	5. Discharge from your ears?	☐	☐	☐

G. Have you ever experienced any of the following symptoms? Are they constant or in episodes?

YES	NO		CONSTANT	EPISODES
☐	☐	1. Double vision	☐	☐
☐	☐	2. Numbness of face or extremities	☐	☐
☐	☐	3. Blurred vision or blindness	☐	☐
☐	☐	4. Weakness in arms or legs	☐	☐
☐	☐	5. Clumsiness in arms or legs	☐	☐
☐	☐	6. Confusion or loss of consciousness	☐	☐
☐	☐	7. Difficulty with speech	☐	☐
☐	☐	8. Difficulty with swallowing	☐	☐
☐	☐	9. Tingling around the mouth	☐	☐
☐	☐	10. Spots before the eyes	☐	☐

PAAB