DIZZINESS QUESTIONNAIRE

Name: _____ Date of Testing_____

Referring Physician: _____ Primary Complaint_____

- **In your own words, please describe your dizziness/lightheadedness/vertigo:**

_____
_____
_____

- **When did this first begin?_____**
- **Do you experience the problem constantly or in attacks? (please circle)**
- **How often does it occur?_____**
- **How long does it last?_____**
- **If your dizziness occurs in attacks, do you have any warning that the attack is about to start?**

_____
_____

- **Do you know of a possible cause of your dizziness? Please describe:_____**

_____

- **Do you know of anything that will: (please circle)**
  - **Stop your dizziness or make it better? YES NO**
  - **Make your dizziness worse? YES NO**
  - **Precipitate an attack? YES NO**

  Please describe:_____

  _____

- **Does your "dizziness" occur only in certain positions? If so, please describe:_____**

_____

When you are "dizzy", do you experience any of the following sensations? Before answering, please read the entire list. Simply circle YES or No to the sensation that best describes what you are feeling:

1. **Lightheadedness YES NO**
2. **"Swimming" Sensation in your head YES NO**
3. **Objects spinning around you YES NO**
4. **Sensation that you are turning or spinning inside, with outside objects remaining stationary YES NO**
5. **Blacking Out YES NO**

6. **Loss of Consciousness.** YES NO
7. **Tendency to fall: To the Right?** YES NO
   To the Left? YES NO
   Forward? YES NO
   Backward? YES NO
8. **Loss of balance when walking: Veering to the *right?*** YES NO
   left? YES NO
9. **Headache?** YES NO
10. **Nausea or vomiting?** YES NO
11. **Pressure in your head?** YES NO

PLEASE CIRCLE YES OR NO AND FILL IN THE BLANKS:

1. **Do you have trouble walking in the dark?** YES NO
2. **Do you have any allergies?** YES NO
3. **Did you ever have a head injury?** YES NO
   - **Were you unconscious?** YES NO

4. **Do you use tobacco?** YES NO
   - **How Much?**_____
5. **Do you use alcohol?** YES NO
   - **How much?**_____

6. **Do you use recreational drugs?** YES NO
   - **How often?**_____

7. **Do you take prescription medications?** YES NO
   - **Please list the medications you take on a regular basis:**_____
   _____
   _____
   _____

PLEASE ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR EARS AND HEARING: SIMPLY CIRCLE YES OR NO

1. **Difficulty hearing?** YES NO
   - **If so, please circle: Right Left Both Ears**
   - When did you first notice the hearing loss?_____

2. **Ringing or noise in your ears?** YES NO
   - **If so please circle: Right Left Both Ears**
   - Describe the noise:_____
   _____
   - **Does the noise change with dizziness? Please describe:**_____

_____

■ **Does anything stop the noise or make it better? Please describe:_____**

_____

3. **Fullness in your ears? YES NO**
   - **If so, please circle: RIGHT LEFT BOTH EARS**
   - **Does this change when you are dizzy? Please describe_____**

   _____

4. **Pain in your ears? YES NO**

   - **If so, please circle: RIGHT LEFT BOTH EARS**

5. **Discharge from your ears? YES NO**

   - **If so please circle: RIGHT LEFT BOTH EARS**

6. **Have you ever had ear surgery? YES NO**

   - **If so, please describe:_____**

   _____

PLEASE CIRCLE YES OR NO IF YOU HAVE EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS:

1. **Double Vision YES NO**
2. **Blurred Vision or Blindness YES NO**
3. **Spots before your eyes YES NO**
4. **Confusion or loss of consciousness YES NO**
5. **Weakness in arms or legs YES NO**
6. **Numbness of your face or extremities YES NO**

PLEASE CIRCLE YES OR NO TO THE FOLLOWING:

1. **Did you get new glasses recently? YES NO**
2. **Do you get dizzy when you have not eaten for a long time? YES NO**
3. **Have you ever had a neck or back injury? YES NO**
4. **Are you exposed to any irritating fumes, paints, solvents, etc? YES NO**
   - **If yes please describe:_____**

   _____

PLEASE LIST, AND/OR DESCRIBE ANY GENERAL HEALTH PROBLEMS YOU ARE CURRENTLY BEING TREATED FOR:

_____

_____

_____

_____