Dizziness Questionnaire

Patient Name: ____ Date____________________

PLEASE ANSWER ALL QUESTIONS

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

Yes___ No___ Lightheadedness
Yes___ No___ Swimming sensation in the head
Yes___ No___ Blacking out
Yes___ No___ Loss of consciousness
Yes___ No___ Tendency to fall:
to the right ___ to the left ___ forward ___ backward ___
Yes___ No___ Objects spinning or turning around you
Yes___ No___ Sensation that you are turning or spinning inside, with outside objects remaining stationary
Yes___ No___ Loss of balance when walking
veering to the right ___ veering to the left___
Yes___ No___ Headaches
Yes___ No___ Nausea or vomiting
Yes___ No___ Pressure in the head

II. Please check either Yes or No and fill in the blank spaces if applicable.

Yes___ No___ My dizziness is constant
Yes___ No___ My dizziness occurs in attacks
When did the dizziness first occur? ____________________________________
How long do they last? ____
How often? ____
Yes___ No___ When an attack is about to start, can you tell?
If so, how? ____
Yes___ No___ Are you completely free of dizziness between attacks?
Yes___ No___ Does a change of position make you dizzy?
Yes___ No___ Do you have trouble walking in the dark?
Yes___ No___ When you are dizzy, can you stand up unsupported?
Yes___ No___ Do you know of any possible cause of your dizziness?
If so, what? ____
Yes___ No___ Is there any relationship between eating and your dizziness?
If so, what? ____

Do you know of anything that will:

Yes___ No___ Bring on an attack? ____

Yes___ No___ Make your dizziness worse? ____

Yes___ No___ Stop your dizziness or make it better? _____________________________

Yes___ No___ Were you exposed to any irritating fumes, paints, etc. at the onset of the dizziness?

Yes___ No___ Do you have any allergies?

Yes___ No___ Did you ever injure your head?

Yes___ No___ Were you ever unconscious?

Yes___ No___ Do you take any medications regularly?
If so, what? ____

Yes___ No___ Do you use tobacco in any form?
If so, how much? ____

Yes___ No___ Do you think you eat a lot of animal fat?

III. Do you have any of the following symptoms?

Yes___ No___ Difficulty hearing? both ears____ right ____ left____

Yes___ No___ Noise in your ear (s)? both ears____ right ____ left____
describe the noise: ____

Yes___ No___ Does the noise change with dizziness?
If so, how? ____

Yes___ No___ Fullness or stuffiness in ear (s)? ? both ears____ right ____ left____
Does this change when you are dizzy? Yes___ No___

Yes___ No___ Pain in your ear (s)? both ears____ right ____ left____

Yes___ No___ Discharge from your ear (s)? both ears____ right ____ left____

IV. Have you experienced any of the following symptoms?

Yes___ No___ Double vision Constant ___ In Episodes___

Yes___ No___ Blurred vision or blindness Constant ___ In Episodes___

Yes___ No___ Numbness in your face Constant ___ In Episodes___

Yes___ No___ Numbness in your arms or legs Constant ___ In Episodes___

Yes___ No___ Weakness in your arms or legs Constant ___ In Episodes___

Yes___ No___ Clumsiness in your arms or legs Constant ___ In Episodes___

Yes___ No___ Confusion or loss of consciousness Constant ___ In Episodes___

Yes___ No___ Difficulty with speech Constant ___ In Episodes___

Yes___ No___ Difficulty with swallowing Constant ___ In Episodes___