EAR NOSE & THROAT SPECIALTIES P.C.

Dizziness Questionnaire

Name_____ Date_____

Which of these best describes your primary symptom of dizziness? Circle only one.

1. A sensation of movement of yourself or the room: spinning, tilting, or wave-like movement
2. Lightheadedness or feeling that you are going to faint
3. Loss of balance
4. Disassociation or disorientation with the world

When you are "dizzy" do you experience any of the following sensations? You may circle as many responses as necessary.

Yes	No	1. Lightheadedness or swimming sensation in the head.
Yes	No	2. Blacking out or loss of consciousness.
Yes	No	3. Tendency to fall.
Yes	No	4. Objects spinning or turning around you.
Yes	No	5. Sensation that you are turning or spinning inside.
Yes	No.	6. Loss of balance when walking
Yes	No	7. Headache
Yes	No	8. Pressure in the head.
Yes	No	9. Nausea or vomiting.

When did the dizziness first occur?_____

When was the last time you experienced these symptoms?_____

Prior to the onset of your dizziness did you experience any of these events?

Yes	No	Head Injury,	when_____
Yes	No	Neck Injury,	when_____
Yes	No	Childbirth,	when_____
Yes	No	Other trauma,	explain_____

Is the dizziness CONSTANT or does it come in ATTACKS? _____

If the dizziness comes in attacks, how often do these attacks occur?

_____times per day / week / month / year.

If the dizziness comes in attacks, how long do the attacks last?

_____ seconds / minutes / hours / days.

What factors provoke the dizziness or make the dizziness worse?

_____

What makes the dizziness better?

_____

Does your hearing change when the dizziness occurs? Yes / No

How?_____ Which Ear? Right / Left

Are you completely free of dizziness between attacks? Circle Yes / No

Do you have any history of a neurological disease:

Yes No 1. Migraine
Yes No 2. Multiple sclerosis
Yes No 3. Stroke
Yes No 4. Other_____

Do you have vitamin B12 deficiency? Yes / No

Do you have any of the following symptoms? Circle Yes or No and if Yes, circle Ear involved.

Yes No 1. Difficulty in hearing? Right Left
Yes No 2. Fullness or stuffiness in your ears? Right Left
Yes No 3. Noise in your ears? Right Left
Yes No 4. Does noise change during the dizziness? How? _____

Have you experienced any of the following symptoms?

Yes No 1. Double vision, blurred vision or blindness.
Yes No 2. Numbness of face.
Yes No 3. Numbness of arms or legs.
Yes No 4. Weakness in arms or legs.
Yes No 5. Clumsiness of arms or legs.
Yes No 6. Confusion or loss of consciousness.
Yes No 7. Difficulty with speech.
Yes No 8. Difficulty with swallowing.
Yes No 9. Pain in the neck or shoulder.

Have you had cancer? Yes / No If yes, did you receive chemotherapy? Yes / No

Have you ever received IV antibiotics? Yes / No If yes, when_____

Have you had any falls? Yes / No Have you come close to falling? Yes / No

Do you take any over-the-counter or prescription medications:

Yes No for dizziness?
Yes No for allergies?
Yes No for pain?
Yes No to help you sleep?
Yes No for depression/anxiety? If yes, how long on same dosage?_____

Do you consume alcohol? Yes / No How many? _____ drinks per day / week

Do you have any known problems with your eyes? Yes / No
If Yes, please explain_____

Have you had eye surgery? Yes / No
If Yes, please explain for what and when_____