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Name: _____

Date: _____

DIZZINESS QUESTIONNAIRE

I. When you are "dizzy," do you experience any of the following sensations? Please read the entire list first. Then circle *Yes* or *No* to describe your feelings most accurately.
Answer all questions.

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: To the right?
Yes *No* To the left?
Yes *No* Forward?
Yes *No* Backward?
Yes *No* 4. Objects spinning around you?
Yes *No* 5. Sensation that you are turning or spinning inside with outside objects remaining still?
Yes *No* 6. Sensation of the environment moving up and down while you walk?
Yes *No* 7. Loss of balance while walking: Veering to the right?
Yes *No* Veering to the left?
Yes *No* 8. Headache?
Yes *No* 9. Nausea or vomiting?
Yes *No* 10. Pressure in the head?
Yes *No* 11. Palpitations, perspiration, shortness of breath, or a feeling of panic?

II. Please circle *Yes* or *No* and fill in the blank spaces. **Answer all questions.**

1. When did dizziness first occur?_____
2. My dizziness is:

Yes *No* Constant?
Yes *No* In Episodes?

3. If in episodes: How often?_____
How long do they last?_____
When was last episode?_____

Yes *No* Do you have any warning that the episode is about to start?
Yes *No* Do they occur at any particular time of day or night?
Yes *No* Are you completely free of dizziness between episodes?
Yes *No* 4. Does change of position make you dizzy?
Yes *No* 5. Do you have trouble walking in the dark?
Yes *No* 6. When you are dizzy, must you support yourself when standing?

Yes *No* 7. Do you know of any possible cause of your dizziness?

8. Do you know of anything that will:

Yes *No* Stop your dizziness or make it better?

Yes *No* Make your dizziness worse?

Yes *No* Precipitate an attack? (Fatigue? Exertion? Hunger? Menstrual period? Stress? Emotional upset?)

Yes *No* 9. Were you exposed to any irritating fumes, paints, etc., at the onset of dizziness?

Yes *No* 10. If you ever injured your head, were you unconscious?

Yes *No* 11. If you **take any medications for the dizziness**, please list:_____

_____

Yes *No* 12. If you are **allergic to any medications**, please list:_____

_____

Yes *No* 13. Do you use tobacco in any form? How much?_____

III. Do you have any of the following symptoms? Please circle *Yes* or *No* and circle *ear involved.*

Yes	*No*	1. Difficulty in hearing?	*Both ears*	*Right*	*Left*
Yes	*No*	2. Fullness or stuffiness in your ears?	*Both ears*	*Right*	*Left*
Yes	*No*	3. Pain in your ears?	*Both ears*	*Right*	*Left*
Yes	*No*	4. Discharge from your ears?	*Both ears*	*Right*	*Left*
Yes	*No*	5. Noise in your ears?	*Both ears*	*Right*	*Left*

Describe the noise: _____

_____

Yes *No* Does the noise change with dizziness? If so, how?_____

_____

IV. Have you experienced any of the following symptoms? Please circle *Yes* or *No* and circle if *Constant* or if *In Episodes.*

Yes	*No*	1. Double vision, blurred vision, or blindness.	*Constant*	*In Episodes*
Yes	*No*	2. Numbness of face.	*Constant*	*In Episodes*
Yes	*No*	3. Numbness of arms or legs.	*Constant*	*In Episodes*
Yes	*No*	4. Weakness in arms or legs.	*Constant*	*In Episodes*
Yes	*No*	5. Clumsiness of arms or legs.	*Constant*	*In Episodes*
Yes	*No*	6. Confusion or loss of consciousness.	*Constant*	*In Episodes*
Yes	*No*	7. Difficulty with speech	*Constant*	*In Episodes*
Yes	*No*	8. Difficulty with swallowing.	*Constant*	*In Episodes*

Yes	*No*	9. Pain in the neck or shoulder.	*Constant*	*In Episodes*
Yes	*No*	10. Seasickness or car sickness.	*Constant*	*In Episodes*