DIZZINESS QUESTIONNAIRE

NAME: _____ **DATE:** _____

1. In your own words, please describe your dizziness or the sensation you are experiencing:

   _____

   _____

   _____

2. When did you experience your first symptom? _____
3. When did you experience your last symptom? _____
4. Have you experienced dizziness in the past? ○ YES ○ NO

   If so, when? _____
5. Describe what will:

   make your symptoms less severe: _____

   make your symptoms more severe: _____
6. Are your symptoms associated with: (i.e. occurring at the same time, beginning, or after)

   fasting or eating? ○ YES ○ NO

   a cold or other infection? ○ YES ○ NO

   a head injury or other accidents? ○ YES ○ NO

   a headache? ○ YES ○ NO
7. Do you have migraine headaches? ○ YES ○ NO
8. Are you taking any medications specifically for your dizziness symptoms? ○ YES ○ NO

   If so, please list: _____

Please choose the best answer:

1. My dizziness is constant, all day long. ○ YES ○ NO
2. My dizziness comes and goes, fluctuates. ○ YES ○ NO
3. My dizziness lasts: ○ SECONDS ○ MINUTES ○ HOURS ○ DAYS ○ OTHER _____
4. I feel like I am spinning or moving. ○ YES ○ NO
5. I feel like I am still, but my surroundings are moving. ○ YES ○ NO
6. My dizziness makes me nauseous or sick feeling. ○ YES ○ NO
7. My dizziness has caused me to vomit. ○ YES ○ NO
8. My dizziness causes the environment to move or bounce when I run or walk. ○ YES ○ NO
9. I become dizzy when:

   things around me move or pass by. ○ YES ○ NO

   I am sitting still in a chair. ○ YES ○ NO

   I am exposed to bright lights. ○ YES ○ NO

   I hear loud sounds or noises. ○ YES ○ NO

Do you have any of the following symptoms:

Double vision? ○ YES ○ NO

Spots before your eyes? ○ YES ○ NO

Difficulty swallowing? ○ YES ○ NO

Difficulty with speech? ○ YES ○ NO

Blurred vision? ○ YES ○ NO

Blindness? ○ YES ○ NO

Numbness in your face, arms, or legs? ○ YES ○ NO

Clumsiness in arms or legs? ○ YES ○ NO

Confusion? ○ YES ○ NO

Change in taste or smell? ○ YES ○ NO

Please choose the best answer to the best of your knowledge:

1. Do you have:
   - difficulty hearing? ○ YES ○ NO
     - if yes, which ear? ○ RIGHT ○ LEFT ○ BOTH
     - which ear is worse? ○ RIGHT ○ LEFT ○ NEITHER
   - ear pain? ○ YES ○ NO
     - if yes, which ear? ○ RIGHT ○ LEFT ○ BOTH
   - drainage from your ears? ○ YES ○ NO
     - if yes, which ear? ○ RIGHT ○ LEFT ○ BOTH
   - pressure or fullness in your ears? ○ YES ○ NO
   - noises in your ears? ○ YES ○ NO
     - if yes, which ear? ○ RIGHT ○ LEFT ○ BOTH
     - do the noises change when you are dizzy? ○ YES ○ NO

     Please describe the noises you experience: _____
2. Does your hearing change, come and go? ○ YES ○ NO

   If yes, please describe: _____
3. Do you feel that your hearing loss is related to your symptoms of dizziness? ○ YES ○ NO

   If yes, please explain: _____

Please choose the best answer.

1. Do you experience:
   - lightheadedness? ○ YES ○ NO
   - sensation that you are going to black out? ○ YES ○ NO
   - blackouts? ○ YES ○ NO
   - loss of consciousness? ○ YES ○ NO
   - falling to the right? ○ YES ○ NO
   - falling to the left? ○ YES ○ NO
   - falling forward? ○ YES ○ NO
   - falling backward? ○ YES ○ NO
2. Do any of the following actions make you dizzy?
   - turning over in bed? ○ YES ○ NO
   - getting out of bed? ○ YES ○ NO
   - looking up? ○ YES ○ NO
   - standing quickly? ○ YES ○ NO
   - walking? ○ YES ○ NO
   - standing or walking in the dark? ○ YES ○ NO
   - standing or walking on uneven surfaces? ○ YES ○ NO
   - riding in a car? ○ YES ○ NO

If other changes in position or movements make you dizzy, please describe them:

_____

_____

_____