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# *DIZZINESS QUESTIONAIRE*

***Please answer the following brief questions about your dizziness (circle your answers):***

1. Do you have hearing loss (now or in the past)? YES NO

2. Do you have TRUE VERTIGO (false sense of motion, floating, bobbing, swaying, rocking, tilting, or spinning)? YES NO

If **YES**, how long did it last?
1. SHORT EPISODES: less than 5 minutes.
2. MODERATE EPISODES: 5 minutes to 24 hours.
3. LONG EPISODES: 1 day to 1 week.
4. PERSISTENT: Longer than 1 week.

If **NO**, do you have any of the following symptoms?

A. DYSEQUILIBRIUM (imbalance): Off balance, tipsy, wobbly, feeling you might fall.

B. NEAR FAINTING: Near feeling you might faint, black out, or lose consciousness.

C. SPACEY: Disconnected or distanced from the world from the world around you, panicky, tingling about the mouth or hands.

If so, how long do these symptoms last?
1. SHORT EPISODES: Less than 5 minutes.
2. MODERATE EPISODES: 5 minutes to 24 hours.
3. LONG EPISODES: 1day to 1 week.
4. PERSISTANT: longer than 1 week.

NAME________________________ DATE________________

## DIZZINESS QUESTIONNAIRE

IS YOUR DIZZINESS ASSOCIATED WITH ANY OF THE FOLLOWING SENSATIONS? PLEASE READ THE ENTIRE LIST FIRST. THEN CIRCLE YES OR NO TO DESCRIBE YOUR FEELINGS MOST ACCURATELY.

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, with outside objects remaining stationary.
Yes No 6. Loss of balance when walking in the light:
Veering to the: Right? Left?
Yes No 7. Loss of balance when walking in the dark:
Veering to the: Right? Left?
Yes No 8. Headache.
Yes No 9. Nausea.
Yes No 10. Vomiting
Yes No 11. Pressure in the head.
Yes No 12. Tingling in the fingers or toes.
Yes No 13. Tingling around the mouth.

TIME COURSE & AGGRAVATING FACTORS

1. When did your dizziness first occur?________________
2. How often do you become dizzy?________________
3. If in attacks, how long does an attack last?________________
Yes No 4. Do you have any warning that the attack is about to start?
Yes No 5. Do they occur at any particular time of day or night?
Yes No 6. Are you completely free of dizziness between attacks?
Yes No 7. Does change of position make you dizzy? Which movement?
________________________________
Yes No 8. Do you become dizzy when rolling over in bed?
To the right? To the left?
Yes No 9. Do you know of any possible cause for your dizziness?
What?________________________________
10. Do you know of anything that will:
Yes No a. Stop your dizziness or make it better?________________
________________________________
Yes No b. Make your dizziness worse?________________
________________________________
Yes No 11. Do you become dizzy when you bend your head forward________
backward________
Yes No 12. Do you become dizzy when you cough?________________
When you sneeze?________________
When you have a bowel movement?________________

13. Can any of the following make your dizziness worse or precipitate an attack?

Yes No Fatigue?
Yes No Exertion?
Yes No Hunger?
Yes No Menstrual Period?
Yes No Stress?
Yes No Emotional Upset?
Yes No Alcohol?
Yes No 14. Do you have any allergies? What?________________________

________________________________________

ASSOCIATED OTOLOGIC SYMPTOMS

Do you have any of the following symptoms? Please circle Yes or No and circle the ear involved, if appropriate.

Yes No 1. Dizziness. Describe dizziness________________________

________________________________________

Yes No 2. Difficulty in hearing? Both Ears______ Right________ Left________
Yes No 3. Does your hearing change with dizziness?
If so, how?________________________________

________________________________________

Yes No 4. Do you have noise in your ears? Both Ears____________
Right__________ Left__________
Describe Noise:________________________

________________________________________

Yes No 5. Does noise change with dizziness?
If so, how?________________________________

________________________________________

Yes No 6. Do you have fullness or stuffiness in your ears?
Both Ears________ Right________ Left________
Yes No 7. Do you have pain in your ears? Both Ears__________
Right__________ Left__________
Yes No 8. Do you have discharge from your ears? Both Ears________
Right__________ Left__________

ASSOCIATED NEUROLOGIC SYMPTOMS

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

| | | | | | |
|---|---|---|---|---|---|
| Yes | No | 1. | Double Vision | Constant______ | In Episodes______ |
| Yes | No | 2. | Blurred Vision | Constant______ | In Episodes______ |
| Yes | No | 3. | Blindness | Constant______ | In Episodes______ |
| Yes | No | 4. | Numbness of Feet or Extremities | Constant______ | In Episodes______ |

| | | | | | |
|---|---|---|---|---|---|
| Yes | No | 5. | Weakness in arms or legs | Constant_____ | In Episodes______ |
| Yes | No | 6. | Clumsiness of the arms or legs. | Constant_____ | In Episodes______ |
| Yes | No | 7. | Confusion or loss of consciousness. | Constant_____ | In Episodes______ |
| Yes | No | 8. | Difficulty with speech. | Constant_____ | In Episodes______ |
| Yes | No | 9. | Difficulty with swallowing. | Constant_____ | In Episodes______ |
| Yes | No | 10. | Pain in neck or shoulders | Constant_____ | In Episodes______ |

PAST MEDICAL HISTORY

Yes No 1. Do you have a history of earaches or ear infections as a child?______________________________

Yes No 2. Did you ever injure your head?_______ When?___________________

Yes No 3. Were you ever unconscious?_______ When?______________________

Yes No 4. Did you suffer from motion sickness before age 12?___________

Yes No 5. Have you suffered from motion sickness in the last 10 years?

Yes No 6. Do you now take any medications regularly? What?___________

Yes No 7. Have you taken medications in the past for dizziness? What?__________________________________

Yes No 8. Do you use tobacco in any form? What kind?_______________ How much?__________________________________

Yes No 9. Does caffeine affect your dizziness? How?________________

Yes No 10. Does alcohol affect your dizziness? How?__________________

Yes No 11. Do you have a past history of: Diabetes?_______ Heart Disease?________ High Blood Pressure?_______ Kidney Disease?________ Thyroid Disease?__________ Migraine Headache?__________

Yes No 11. Do you have a family history of: Ear Disease?__________ Neurologic Disease?__________ Migraine Headaches?_________