WMCHealth **Physicians**
Advanced ENT Services

DIZZINESS QUESTIONNAIRE

Name____ Date______________

I When you are "dizzy" do you experience any of the following sensations? Please read the entire list first.

Then check 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: To the right?
Yes ☐ No ☐ To the left?
Yes ☐ No ☐ Forward?
Yes ☐ No ☐ Backward?
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. Sensation of the environment moving up and down while you walk.
Yes ☐ No ☐ 7. Loss of balance when 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 check yes or no and fill in the blank spaces. <u>Answer all questions</u>.

1. My dizziness is:

Yes ☐ No ☐ Constant?
Yes ☐ No ☐ In attacks?

2. When did dizziness first occur?______________________

3. If in attacks: How often?______________________

How long do they last?______________________

When was the last attack?______________________

Yes ☐ No ☐ Do you have any warning that the attack 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 attacks?
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?

(Please turn page and finish questionnaire.)

Yes ☐ No ☐ 7. Do you know of any possible cause of your dizziness? What?________________

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 are allergic** to any medications, please list:________________

____

Yes ☐ No ☐ 11. If you ever injured your head, were you unconscious?

Yes ☐ No ☐ 12. **If you take any medications** regularly, for any reason, please list:________

____

Yes ☐ No ☐ 13. Do you use tobacco in any form?________ How much?________

III Do you have any of the following symptoms? Please check yes or no and check ear involved.

Yes ☐	No ☐	1. Difficult in hearing?	Both ears ☐	Right ☐	Left ☐
Yes ☐	No ☐	2. Noise in your ears?	Both ears ☐	Right ☐	Left ☐

2a. How loud is your tinnitus or head noise most of the time?

☐ None	No head noise.
☐ Very Soft	Heard only in a quiet situation.
☐ Moderate	Heard only in an ordinary situation.
☐ Loud	Heard and noticed in all situations, even when concentrating on something else.

2b. Describe the noise________________

2c. Does noise change with dizziness? If so, how?________________

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Yes ☐	No ☐	3. Fullness of stuffiness in your ears?	Both ears ☐	Right ☐	Left ☐
Yes ☐	No ☐	4. Pain in your ears?	Both ears ☐	Right ☐	Left ☐
Yes ☐	No ☐	5. Discharge from your ears?	Both ears ☐	Right ☐	Left ☐

IV Have you ever experienced any of the following symptoms? Please check yes or no and check constant or 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 of 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 ☐