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# Dizziness Questionnaire

Name ____________________________________________ Date ________________
DOB _____________________________________________

***Please take your time and fill out this form very carefully. Medical decisions will be made based on the information given on this sheet.***

**ALL OF THE FOLLOWING INFORMATION IS NEEDED.**

**Please circle YES or NO for each of the following questions:**

1. **Regarding your dizziness:**
   YES NO Do you have more than one type of dizziness?
   YES NO Is dizziness your most important complaint now?

2. **If some other symptom is your most significant complaint, what is it**? ______________________________
   ______________________________________________________________________

3. **Which of the following best describes your dizziness?**
   YES NO Spinning Sensation
   If yes for spinning, please choose one:
   A. Does the whole world spin in circles?
   B. OR does your head spin in circles?
   C. OR is it an off-balance sensation?

   YES NO "Swimming" in the head
   YES NO Light-headedness
   YES NO Feeling like I'm going to pass out
   YES NO Difficulty with coordination
   YES NO Rocking sensation
   YES NO Panic feelings

4. **During an attack of dizziness:**
   YES NO Is it difficult to stand up?
   YES NO Are you nauseated?
   YES NO Do you vomit?
   YES NO Does your hearing change?

5. **During an attack of dizziness, do you have:**
   YES NO Double vision?
   YES NO Numbness or tingling of the face, arm, or leg?
   YES NO Weakness of an arm or leg?

6. **During an attack of dizziness, do you have:**
   YES NO Inability to see on one side or "holes" in your vision?
   YES NO Difficulty with speech?
   YES NO Difficulty with swallowing?
   YES NO Skipping or irregular heartbeats?
   YES NO Clumsiness?
   YES NO Confusion?
   YES NO Feeling things are unreal?

7. **How does your dizziness change under the following circumstances?**

| | Brings on Dizziness | Gets Worse | No Change |
|---|---|---|---|
| Standing up quickly | ❒ | ❒ | ❒ |
| Rolling over in bed | ❒ | ❒ | ❒ |
| Looking up | ❒ | ❒ | ❒ |
| Riding in a car or plane | ❒ | ❒ | ❒ |
| Missing a meal; going hungry | ❒ | ❒ | ❒ |
| Eating a meal | ❒ | ❒ | ❒ |
| Hearing a loud noise | ❒ | ❒ | ❒ |
| Opening your eyes | ❒ | ❒ | ❒ |
| Walking on uneven ground | ❒ | ❒ | ❒ |
| Watching a flickering light | ❒ | ❒ | ❒ |
| Facing a tense situation | ❒ | ❒ | ❒ |
| In a small, crowded room | ❒ | ❒ | ❒ |
| Strenuous physical exertion | ❒ | ❒ | ❒ |
| Coughing or Straining | ❒ | ❒ | ❒ |

   YES NO Have you fallen because of your dizziness?
   YES NO Have you had seizures related to your dizziness?

8. **When did your first dizziness episode occur?**
   ____________________________________________________________

9. **Which best describes your dizziness:**
   YES NO Present all the time?
   YES NO Comes in attacks/episodes?
   If you have attacks/episodes:
   How often do they occur? ________________________________________
   How long do they last? __________________________________________

**10. Between attacks of dizziness:**

YES NO Do you have some dizziness?
YES NO Do you have difficulty walking in the dark?
YES NO Is your hearing better?

**11. In the past were you:**

YES NO Able to tell an attack of dizziness was coming?
YES NO Susceptible to motion sickness?
YES NO Overcome by fumes, paint, or smoke?
YES NO Able to identify a possible cause of your dizziness?
If so, what was the cause? ____________________________________________________
______________________________________________________________________
YES NO Ever knocked unconscious?
If so, when? ____________________________________________________________
YES NO Ever shown to be allergic to something?
If so, to what? __________________________________________________________
YES NO Have you had any ear or brain surgery?
If so, when? ____________________________________________________________
YES NO Have you ever had a serious neck injury or neck surgery?
If so, when? ____________________________________________________________
YES NO Do you use tobacco?
YES NO Do you use caffeine (coffee, tea, or caffeinated sodas)?
If so, how many cups per day? _______________________________________________

**12. Do you:**

YES NO Have trouble hearing?
If yes, which ear? Right Left Both
YES NO Have noise in your ears?
If yes, which ear? Right Left Both
YES NO If you have noise in your ears, does the noise change with your dizziness?
If yes, how does it change? _________________________________________________
YES NO Feeling of fullness or pressure in your ears?
If yes, which ear? Right Left Both
YES NO Does the fullness change with your dizziness?
If yes, how does it change? _________________________________________________
YES NO Have pain in your ears?
If yes, which ear? Right Left Both
YES NO Have drainage of liquid from your ears?
If yes, which ear? Right Left Both
YES NO Have ringing in your ear?
If yes, which ear? Right Left Both
YES NO Have any other ear symptoms?
If yes, please list: _________________________________________________________
______________________________________________________________________

**13. If you have taken any medications, please answer the following:**

YES NO Have you taken medications for dizziness?
If yes, please list: _________________________________________________________
______________________________________________________________________

YES NO Did any medications help?
Which medication helped the most? ____________________________________________

YES NO Have you taken any medications for headaches, sinus conditions, allergy, or any ear, nose, or throat disorder?
If yes, please list: ____________________________________________________________
______________________________________________________________________________

YES NO Do you take medications regularly (for something else)?
If yes, please list: ____________________________________________________________
______________________________________________________________________________

YES NO Have you ever had any ear operations?
If yes, please list: ____________________________________________________________
______________________________________________________________________________

**14. Have you undergone any of the following tests?**

YES NO Hearing Test
YES NO Balance Test
YES NO Spinal Tap
YES NO Neurologic examination
YES NO Skull X-Ray
YES NO Head Scan/ CT Scan/ MRI
If yes, Circle above.
YES NO Eye Test

**15. Do you wear hearing aids or did you previously wear hearing aids?** YES NO

If yes, how long have you worn them?
Make: ____________________________ Model: _______________________ SN: ___________________________
Make: ____________________________ Model: _______________________ SN: ___________________________

**16. What have your occupations been?**

______________________________________________________________________________
______________________________________________________________________________

Please feel free to add any additional information you feel we may need to know to further evaluate your dizziness:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

_______________________________________________ _________________________
Patient Signature Date