DIZZINESS QUESTIONAIRE

NAME ______________________________
DATE ________________ BP ___________

I. My first episode of dizziness occurred (approximate date): ____________________________
Describe: ____
____

II. When you are "dizzy" do experience the following?

(Yes)	(No)		(Yes)	(No)	
( )	( )	lightheadedness	( )	( )	nausea
( )	( )	swimming sensation in head	( )	( )	vomiting
( )	( )	feeling faint	( )	( )	pressure in the head
( )	( )	blacking out or loss of consciousness	( )	( )	headache
( )	( )	environment spinning around you	( )	( )	loss of balance when walking
( )	( )	veering to the right when walking	( )	( )	veering to the left when walking

III. Please check below:

(Yes) (No)
( ) ( ) my dizziness is constant. If yes, since when ________________________________
( ) ( ) my dizziness is in attacks. If yes,
Do you know of anything that precipitates an attack? ___________________________
How often are the attacks? ____
How long do they last? ____
Are you completely free of dizziness between attacks? _________________________
( ) ( ) does your dizziness occur only in certain positions?
Describe ____
( ) ( ) do you know of any possible cause of your dizziness?
What? ____
( ) ( ) do you know of anything that stops your dizziness or makes it better?
What? ____
( ) ( ) do you know of anything that makes your dizziness worse?
What? ____

IV. Further description of your dizziness or vertigo: ________________________________
____
____

V. Do you have any of the following?

(YES) (NO) check which ear (R) (L) (Both)
( ) ( ) difficulty hearing…………………………………………….. ( ) ( ) ( )
when did this start? __________________
is it getting worse? ___________________
( ) ( ) noise in your ears……………………………………………. ( ) ( ) ( )
describe the noise _______________________
if it occurs or changes with your dizziness? How? ____________
____
( ) ( ) fullness in your ears………………………………………….. ( ) ( ) ( )

( ) ( ) does the fullness change with your dizziness, how? ___________
____
( ) ( ) discharge from your ears………………………………………. ( ) ( ) ( )
( ) ( ) pain in your ears……………………………………………… ( ) ( ) ( )
( ) ( ) ear surgery……………………………………………………. ( ) ( ) ( )
date & procedure ______________________________________

PLEASE TURN OVER

NAME ________________________
DATE _________________________

IV. Do you have any of the following? (if yes, check [constant] or [in episodes])

(YES)	[constant]	[in episodes]	(NO)	
( )	[ ]	[ ]	( )	double vision
( )	[ ]	[ ]	( )	spots before the eyes
( )	[ ]	[ ]	( )	blurred vision
( )	[ ]	[ ]	( )	blindness or darkening of vision
( )	[ ]	[ ]	( )	weakness in face or extremities
( )	[ ]	[ ]	( )	numbness in face or extremities
( )	[ ]	[ ]	( )	clumsiness in hands or legs
( )	[ ]	[ ]	( )	confusion
( )	[ ]	[ ]	( )	headache
( )	[ ]	[ ]	( )	difficulty with speech
( )	[ ]	[ ]	( )	difficulty swallowing
( )	[ ]	[ ]	( )	tingling around your mouth
( )	[ ]	[ ]	( )	dizziness after exertion or overwork
( )			( )	new glasses prescribed lately
( )			( )	dizziness when not eaten for a long time
( )			( )	dizziness associated with menstrual period
( )			( )	neck injury (when? ______________________________)
				(how? ___________________________________)
( )			( )	head injury (when? ______________________________)
				(how? ___________________________________)
				If you lost consciousness, how long? _______________

VII. Further Information:

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