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DIZZINESS QUESTIONNAIRE

Patient Name:______________________________ Date:___________________________

How long you have had this problem: ____Years ____Months ____Days

Are you dizzy all of the time? Yes No With motion only

Does the dizziness occur in attacks? Yes No With motion only

If yes:

How often do you have an attack?____

How long does the average attack last?____

When was the first time you had an attack?____

What were you doing when you became dizzy?____

Are you completely free from dizziness between attacks? Yes No

When you are dizzy

Does your ear feel plugged or stopped up? Yes No

Does your ear ring or buzz? Yes No

Do you feel a spinning sensation? Yes No

Do you black out or faint? Yes No

Do you have a tendency to fall or veer to one side when walking?_________________________

Have you ever had an injury to your head? Yes No

If yes:

When was the injury?____

What happened?____

Were you knocked unconscious? Yes No

Was your skull fractured? Yes No

Check any of the following that describes your dizziness:

Disorientation	Tendency to fall	Lightheadedness
Room spinning	Weakness	Occurs with movement in bed
Blackout or faint	Awakens you from sleep	Loss of balance when walking
Occurs at night	Loss of memory	Occurs during the day

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Check any of the following that occur before, during, or after you have a dizziness attack:

Headaches	Pain in your ear(s)	Nausea
Numbness in your face	Difficulty with speech	Vomiting
Blurred Vision	Noise in your ear(s)	Weakness in arms or legs
Pressure in your ear(s)	Pain in neck or shoulder	Excessive sweating

Check if you have any of the following:

Diabetes	Heart trouble	Asthma
Stroke	Allergies	Tuberculosis
Sinus trouble	Kidney trouble	High blood pressure
Venereal Disease	AIDS or HIV+	

Check any of the following that pertain to your vision:

Wear glasses	Wear contact lenses	Have glaucoma
Have cataracts	Cannot close both eyes	

When was your last eye exam?______________________________

Have you seen your primary care doctor about your dizziness? Yes No

If yes:

Do they think your dizziness is medication related? Yes No

Do they think your dizziness is heart related? Yes No

Do they think your dizziness is ear related? Yes No

What treatment did they suggest?______________________________

Did the treatment decrease your dizziness? Yes No