DIZZY QUESTIONNAIRE

PATIENT NAME:_____ DOB:_____ DATE:_____

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PLEASE COMPLETE BEFORE YOUR APPOINTMENT

I. **Please circle** which of the following choices most closely describe your dizziness (**you can choose more than one):**

A. Lightheadedness ("cloudy in the head or head rush")
B. Imbalance ("feel unsteady when walk, stand, or sit")
C. Vertigo ("you or the room are moving or SPINNING")
D. Fainting or feeling you will faint
E. Falling

If you circled A. Lightheadedness How long did it last?_____ How many times did it occur?_____
If you circled B. Imbalance How long did it last?_____ How many times did it occur?_____
If you circled C. Vertigo How long did it last?_____ How many times did it occur?_____
If you circled D. Fainting How many times did it occur?_____
If you circled E. Falling How many times did it occur?_____

How fast does your dizziness come on: Suddenly Slowly

II. **Please describe** in your own words your dizziness:

_____
_____
_____
_____

III. **Please *fill* in** the blank spaces:

When was your first dizzy episode?_____ last episode?_____

How often do attacks occur?_____

How long does each attack last?_____

What will bring on your dizziness?_____

What will stop your dizziness?_____

What will make your dizziness worse?_____

What do you suspect is the cause of your dizziness?_____

IV. Please **circle yes or no** about your dizziness:

Is your dizziness worse with your eyes open?	yes	no
Is your dizziness worse with your eyes closed?	yes	no
Is your dizziness constant?	yes	no
Does your dizziness come in attacks?	yes	no
Has the dizziness lessened in severity?	yes	no

V. Please **circle yes or no** if you experience any of the following ***<u>with your dizziness:</u>***

Headache	yes	no			
Nausea	yes	no			
Vomiting	yes	no			
Difficulty hearing	yes	no	if so which ear	right	left
Ear noises (buzz, chirp, crickets)	yes	no	if so which ear	right	left
Ear pressure	yes	no	if so which ear	right	left
Ear pain	yes	no	if so which ear	right	left
Ear Drainage	yes	no	if so which ear	right	left
Blurred vision	yes	no			
Numbness in arms, hands	yes	no	if so which ear	right	left
Numbness in legs, feet	yes	no	if so which ear	right	left
Weakness in arms, hands	yes	no	if so which ear	right	left
Weakness in legs, feet	yes	no	if so which ear	right	left
Slurred Speech	yes	no			

VI. Please **circle yes or no** if you experience any of the following ***<u>at any time in the past:</u>***

Have you ever injured your head?	yes	no
Do you have a history of migraines?	yes	no
Do you suffer from motion sickness?	yes	no
Have you ever had ear surgery?	yes	no
Have you ever worked in a noisy environment?	yes	no
Have you ever been in the military?	yes	no
Have you ever shot guns for recreations?	yes	no
Do you have a history of ear infections?	yes	no