



Patient Name: _____

DOB: _____

Today's date: _____

Dizziness Questionnaire

1) a) When did your dizziness symptoms begin? b) When was your most recent attack?	
2) When you are "dizzy," do you experience any of the following? (please check all that apply)	
<input type="checkbox"/> Lightheadedness <input type="checkbox"/> Swimming sensation in your head <input type="checkbox"/> Loss of balance or unsteadiness <input type="checkbox"/> Sensation that you are spinning or turning <input type="checkbox"/> Headaches or migraines <input type="checkbox"/> Feeling like you're on a boat	<input type="checkbox"/> Numbness/tingling in your feet <input type="checkbox"/> Numbness/tingling in your hands <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Changes in vision <input type="checkbox"/> Pressure in your head <input type="checkbox"/> Fainting/loss of consciousness
3) Do you have ear symptoms?	
<input type="checkbox"/> Hearing loss or changes in hearing <input type="checkbox"/> right ear <input type="checkbox"/> left ear <input type="checkbox"/> both <input type="checkbox"/> not sure <input type="checkbox"/> Tinnitus (ringing, buzzing, hissing in your ears) <input type="checkbox"/> right ear <input type="checkbox"/> left ear <input type="checkbox"/> both <input type="checkbox"/> not sure	<input type="checkbox"/> Pressure/fullness in your ears <input type="checkbox"/> right ear <input type="checkbox"/> left ear <input type="checkbox"/> both <input type="checkbox"/> not sure <input type="checkbox"/> Have you had hearing testing in the past? <input type="checkbox"/> yes <input type="checkbox"/> no
4) Please describe your first episode (without using the word "dizzy" or "vertigo"):	
5) Is your dizziness <input type="checkbox"/> constant <input type="checkbox"/> in attacks or episodes	
6) How long do your episodes of dizziness last?	
<input type="checkbox"/> less than a minute <input type="checkbox"/> more than a minute <input type="checkbox"/> 10-30 minutes <input type="checkbox"/> 30-60 minutes <input type="checkbox"/> several hours <input type="checkbox"/> days	
7) How often do these episodes occur? <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other:	
8) Do you have any warning signs that your episode is going to occur? <input type="checkbox"/> Yes <input type="checkbox"/> No If <u>yes</u> , please specify:	
9) Are you completely free of dizziness between episodes? <input type="checkbox"/> Yes <input type="checkbox"/> No	
10) What activities decrease your dizziness symptoms (please check all that apply)? <input type="checkbox"/> Lying <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Sleeping <input type="checkbox"/> Medication <input type="checkbox"/> Other:	
11) What activities increase your dizziness symptoms (please check all that apply)? <input type="checkbox"/> Lying <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking <input type="checkbox"/> Bending <input type="checkbox"/> Looking up and/or down <input type="checkbox"/> Turning your head to the right or left <input type="checkbox"/> Other:	

Please complete the reverse side.

Dizziness Questionnaire Cont

Name: _____

12) Does rolling over and/or sitting up in bed make you feel dizzy? If yes, which direction is worse? <input type="checkbox"/> right side <input type="checkbox"/> left side <input type="checkbox"/> not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No
13) Since it started, has your dizziness gotten <input type="checkbox"/> better <input type="checkbox"/> worse <input type="checkbox"/> stayed the same	
14) Have you fallen as a result of your dizziness? Do you have a tendency to fall <input type="checkbox"/> to the right <input type="checkbox"/> to the left <input type="checkbox"/> forward <input type="checkbox"/> backward <input type="checkbox"/> not sure	<input type="checkbox"/> Yes <input type="checkbox"/> No
15) Have you suffered from recent head trauma or upper respiratory infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No
16) Did you travel on a boat/cruise before your dizziness began?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17) Do you suffer from seasonal/environmental allergies? If yes, what medications do you take? Please list:	<input type="checkbox"/> Yes <input type="checkbox"/> No
18) Do you have high/low blood pressure? <input type="checkbox"/> High <input type="checkbox"/> Low <input type="checkbox"/> Neither If yes, is it controlled by medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No
19) Do you have difficulty/pain moving your head or neck?	<input type="checkbox"/> Yes <input type="checkbox"/> No
20) Do you have cataracts or lens implants?	<input type="checkbox"/> Yes <input type="checkbox"/> No
21) Do you drink alcohol? If yes, how often?	<input type="checkbox"/> Yes <input type="checkbox"/> No
22) Do you engage in recreational drug use?	<input type="checkbox"/> Yes <input type="checkbox"/> No
23) Do you use tobacco products?	<input type="checkbox"/> Yes <input type="checkbox"/> No
24) a) Have you seen a medical provider for your dizziness? If yes, where were you seen? b) Were you given medication/s for your dizziness? If yes, please list: c) Did the medication help?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
25) Have you had any diagnostic testing (e.g. bloodwork, MRI, CT, etc.) since your dizziness began? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, where was the imaging done?	

For office use only:

What medications were taken in the last 24 hours?	
Did you have caffeine in the last 24 hours? Did you have alcohol in the last 48 hours?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
Have your symptoms changed since your last office visit?	<input type="checkbox"/> Yes <input type="checkbox"/> No