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Dizziness Questionnaire

Patient Name: _____ Age:_____ Date:_____

Thank you for taking the time to fill out this questionnaire regarding your condition. Dizziness is a very complex condition. Completing these questions to the best of your ability will assist the physician in efficiently and accurately reaching a diagnosis.

1. When did your dizziness first occur? _____
2. Is the dizziness constant? □ Yes □ No
3. Does the dizziness occur in attacks? □ Yes □ No
4. How long are the attacks? _____
5. How frequently does the dizziness occur?
   □ Multiple times daily □ Every 2-3 months
   □ Daily □ A couple of times a year □ Monthly
6. How long does each episode of dizziness last?
   □ Seconds □ Minutes □ 2-3 Hours
   □ More than 3 hours but less than a day □ Days
7. Did you ever have any episodes of dizziness prior to this most recent occurrence? If yes, what is the approximate date when the first episode of dizziness occurred? _____
8. Please describe what you were doing when the very first experience of dizziness occurred.
   _____
   _____
   _____
   _____
9. Have you ever stumbled or fallen because of the dizziness?
   If you have stumbled or fallen, to which side do you stumble or fall?
   □ Right □ Left □ Forward □ Backward
10. If the dizziness occurs in certain positions, in which positions does it occur?
    □ Upright □ Lying flat
    □ Turning to the right □ Turning to the left
11. What makes your dizziness better? _____
12. What makes your dizziness worse? _____
13. When you are dizzy, do you experience any of the following?
    Please check the boxes that most accurately describe your experience.
    □ Light headedness □ Sensation that you are turning
    □ Blacking out □ Sensation that things are turning around you
    □ Nausea / Vomiting □ Sensation as though you are on a merry-go-round
    □ Loss of Consciousness □ Sensation as though you are on a boat
    □ Fainting □ Sensation as though you are bouncing up and down
    □ Pressure in the head □ Imbalance
    □ Spinning □ Headache
14. Do you suffer easily from motion sickness currently or as a child? □ Yes □ No
15. Do you currently have or had migraines? □ Yes □ No
16. Do you drink coffee? _____ How much?_____
    Do you drink alcohol? _____ How much?_____

17. Have you ever seen a specialist for this problem before? If so, please give the name of the doctor(s) and his or her specialty as well as the outcome or treatments if applicable.

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18. Do you take any of the following medications on a regular basis?
    - □ Allergy Pills
    - □ Antihistamines
    - □ Muscle Relaxants
    - □ Aspirin
    - □ High blood pressure medications
    - □ Herbal / Homeopathic Medications
    - □ Decongestants
    - □ Tranquilizers
    - □ Psychotropic medications
    - □ Anti-dizziness medications
    - □ Antibiotics
    - □ Pain medications
19. When the dizziness occurs, do experience any of the following?
    - □ Pressure in the ear(s)
    - □ Pain in the ear
    - □ Buzzing or any sound in the ear
    - □ Weakness or numbness in arms / legs
    - □ Tingling around mouth
    - □ Hearing loss
    - □ Drainage from the ear
    - □ Headache
    - □ Blurry vision / Double vision
    - □ Flashing lights
20. Have you ever had any of the following?
    - □ Head injury
    - □ Neck injury / Whiplash
    - □ Chronic ear infections
    - □ Diabetes
    - □ Hearing loss
    - □ Drainage from the ear
    - □ Fainting
    - □ Anxiety attacks
    - □ Pressure, fullness or stuffiness in ears
    - □ Exposure to loud sound, gunfire, etc
    - □ Chemotherapy
    - □ Stroke
    - □ Ear surgery (including ear tubes)
    - □ High blood pressure
    - □ Vision issues
    - □ Noise, buzzing or any sound in the ears
    - □ Numbness / weakness of the arms, legs, hands or feet
    - □ Seizure or convulsion
    - □ Hyperventilation
    - □ Difficulty with speech
    - □ Difficulty with swallowing
    - □ Radiation
    - □ Exposure to irritating fumes, paints, chemicals, etc.
21. Do your symptoms occur in any of the following activities?
    - □ Riding in a car, on a boat or in a plane
    - □ Reading
    - □ Hearing loud sounds / noise
    - □ Menstruating (if applicable)
    - □ Nose blowing
    - □ Other (please list)
    - □ Scrolling on a computer screen
    - □ Watching quick movements in a movie
    - □ Turning over in bed
    - □ Eating certain foods
    - □ Exercising

Please write any other information here that you feel will contribute.

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Thank you again for your time and efforts in completing this questionnaire. We look forward to working with you in diagnosing and treating your dizziness.