The Ear, Nose, Throat & Plastic Surgery Associates

DIZZINESS QUESTIONNAIRE

NAME: _____ **DATE:** _____

I.When you are "dizzy", do you experience any of the following sensations? Please read the entire list first. Then put an "x" in either the first box for YES or the second box for NO to describe your feelings most accurately.

YES	NO	
☐	☐	1. Lightheadedness.
☐	☐	2. Swimming sensation in the head.
☐	☐	3. Blacking out.
☐	☐	4. Loss of consciousness.
☐	☐	5. Tendency to fall: (Circle All That Apply) To the right? To the left? Forward? Backward?
☐	☐	6. Objects spinning or turning around you.
☐	☐	7. Sensation that you are turning or spinning inside, with outside objects remaining stationary.
☐	☐	8. Loss of balance when walking: (Circle) Veering to the right? Veering to the left?
☐	☐	9. Headache.
☐	☐	10. Nausea or vomiting.
☐	☐	11. Pressure in the head.

II. Please check box for either YES or NO and fill in the blank spaces.

YES	NO	
☐	☐	1. My dizziness is constant?
☐	☐	In attacks?
☐	☐	2. When did dizziness first occur? _____
☐	☐	3. If in attacks: How often? _____
		How long do they last? _____
☐	☐	Do you have any warning that the attack is about to start?
☐	☐	4. Are you completely free of dizziness between attacks?
☐	☐	5. Does dizziness occur only in certain positions?
☐	☐	6. Do you have trouble walking in the dark?
☐	☐	7. When you are dizzy, must you support yourself when standing?
☐	☐	8. Do you know of any possible cause of your dizziness?
		What? _____
☐	☐	9. Do you know of anything that will:
☐	☐	Stop your dizziness or make it better? _____
☐	☐	Make your dizziness worse? _____
☐	☐	Precipitate an attack? _____
☐	☐	10. Were you exposed to any irritating fumes, paints, etc., at the onset of dizziness?
☐	☐	11. Do you have any allergies? _____
☐	☐	12. Did you ever injure your head?
☐	☐	Were you unconscious?

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DIZZINESS QUESTIONNAIRE Page 2

NAME: _____ **DATE:** _____

YES	NO	
☐	☐	13. Do you take any medications regularly? (i.e. tranquilizers, oral contraceptives, barbiturates, antibiotics) What: _____
☐	☐	14. Do you use tobacco in any form? How much? _____
☐	☐	15. Do you use alcohol?
☐	☐	16. Have you ever had ear surgery?

III. Do you have any of the following symptoms? Put an "x" in either the first box for YES or the second box for NO and circle ear involved.

YES	NO				
☐	☐	1. Difficulty in hearing?	Both Ears	Right	Left
		When did this start? _____			
☐	☐	Is it getting worse? _____			
☐	☐	2. Noise in your ears?	Both Ears	Right	Left
		Describe the noise _____			
☐	☐	Does noise change with dizziness? If so, how? _____			
☐	☐	Does anything stop the noise or make it better? _____			
☐	☐	3. Fullness or stuffiness in your ears?	Both Ears	Right	Left
☐	☐	Does this change when you are dizzy?			
☐	☐	4. Pain in your ears?	Both Ears	Right	Left
☐	☐	5. Discharge from your ears?	Both Ears	Right	Left

IV. Have you ever experienced any of the following symptoms? Put an "x" in either the first box for YES or the second box for NO and circle if Constant or if in Episodes.

YES	NO			
☐	☐	1. Double vision	Constant	In Episodes
☐	☐	2. Numbness of face or extremities	Constant	In Episodes
☐	☐	3. Blurred vision or blindness	Constant	In Episodes
☐	☐	4. Weakness in arms or legs	Constant	In Episodes
☐	☐	5. Clumsiness in arms or legs	Constant	In Episodes
☐	☐	6. Confusion or loss of consciousness	Constant	In Episodes
☐	☐	7. Difficulty with speech	Constant	In Episodes
☐	☐	8. Difficulty with swallowing	Constant	In Episodes
☐	☐	9. Tingling around the mouth	Constant	In Episodes
☐	☐	10. Spots before the eyes	Constant	In Episodes

V. Please check box for either YES or NO

YES	NO	
☐	☐	1. Do you get dizzy after exertion or overwork?
☐	☐	2. Did you get new glasses recently?
☐	☐	3. Do you tend to get upset easily?
☐	☐	4. Do you get dizzy when you have not eaten for a long time?
☐	☐	5. Is your dizziness connected with your menstrual period?
☐	☐	6. Have you ever had a neck injury?