DIZZINESS QUESTIONNAIRE

I. When you are “dizzy” do you experience any of the following sensations? Please read the entire list first, then put an “X” in the box for either Yes or No to describe your feelings most accurately.

YES NO

1. Lightheadedness.
2. Swimming sensation in the head.
4. Loss of consciousness.
5. Tendency to fall:
   - To the right?
   - To the left?
   - Forward?
   - Backward?
6. Objects spinning or turning around you.
7. Sensation that you are spinning inside, with outside objects remaining stationary.
8. Loss of balance when walking and veering:
   - To the right?
   - To the left?
10. Nausea or vomiting.
11. Pressure in the head.

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

YES NO

1. My dizziness is constant.
2. My dizziness comes in attacks.
3. When did dizziness first occur? ______________________________________
4. If in attacks:
   - How often are the attacks? ________________________________
   - How long do they last? _____________________________________
   - What, if any, warning signs do you have prior to an attack?

5. Does dizziness occur in certain positions? ____________________________
6. Are you completely free of dizziness between attacks?
7. Do you have trouble walking in the dark?
8. When you are dizzy, must you support yourself when standing?
9. Do you know of any possible causes for your dizziness?
   - Please list: ___________________________________________________
10. Do you know of anything that will:
    - Stop your dizziness or make it better? _________________________
    - Make your dizziness worse? ________________________________
    - Precipitate an attack? _______________________________________
11. Any exposure to any irritating fumes, paints, etc at the onset of your dizziness?
12. Do you have any allergies? __________________________________________
13. Please list any medications you take regularly: ___________________________

YES     NO

14. Do you use tobacco in any form?
15. Do you use alcohol?

III. Do you have any of the following symptoms? Please mark YES or NO and circle the ear involved.

YES     NO
1. Have you ever had ear surgery?    Right    Left    Both Ears
2. Difficulty in hearing?            Right    Left    Both Ears
3. Fluctuating hearing loss?         Right    Left    Both Ears
4. Do you have fullness in your ears? Right    Left    Both Ears
5. Do you have pain in your ears?    Right    Left    Both Ears
6. Discharge from your ears?         Right    Left    Both Ears
7. Do you have noise in your ears?   Right    Left    Both Ears
   Describe the noise if applicable: _____________________________________
   Does the noise change with dizziness? If so, how? _______________________
   Does anything stop the noise or make it better? __________________________
8. Have you been exposed to, or work in, excessive loud noise?

IV. Have you ever experienced any of the following symptoms? Please mark YES or NO and circle if your symptoms are Constant or 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 / contacts recently?
3. Do you tend to get stressed easily?
4. Do you get dizzy if you have not eaten for a long time?
5. Do you get dizzy when you stand up?
6. Have you ever had a neck or back injury?
VI. Please describe your dizziness in your own words.

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________


1. Does looking up increase your problem?
2. Because of your problem, do you feel frustrated?
3. Because of your problem, do you restrict your travel for business or recreation?
4. Does walking down the isle of a supermarket increase your problem?
5. Because of your problem, do you have difficulty getting into or out of bed?
6. Does your problem significantly restrict your participation in social activities?
7. Because of your problem, do you have difficulty reading?
8. Does performing more ambitious activities like sports, dancing or household chores increase your problem?
9. Because of your problem, are you afraid to leave your home without having someone accompany you?
10. Because of your problem, have you been embarrassed in front of others?
11. Do quick movements of your head increase your problem?
12. Because of your problem, do you avoid heights?
13. Does turning over in bed increase your problem?

14. Because of your problem, is it difficult for you to do strenuous house or yard work?

15. Because of your problem, are you afraid people might think you are intoxicated?

16. Because of your problem, is it difficult for you to walk by yourself?

17. Does walking in down a sidewalk increase your problem?

18. Because of your problem, is it difficult for you to concentrate?

19. Because of your problem, is it difficult to walk around your house in the dark?

20. Because of your problem, are you afraid to stay home alone?

21. Because of your problem, do you feel handicapped?

22. Has your problem placed stress on your relationships with family and friends?

23. Because of your problem, are you depressed?

24. Does your problem interfere with your job or household responsibilities?

25. Does bending over increase your problem?