Dizziness Questionnaire

MRN: _____

NAME:_____AGE:_____DATE: _____

When did the dizziness first occur? _____
What were the circumstances? _____
_____
When was the last time you experienced dizziness? _____
What were the circumstances? _____
_____

Currently, my dizziness . . . (Check ONE)
___ is constant.
___ is always there, but changes intensity.
___ comes and goes.
If it comes and goes:
How long does it typically last? _____ seconds / minutes / hours (Circle ONE)
How often does it typically occur? _____ times per hour / day / week / month / year (Circle ONE)

My dizziness mostly consists of . . . (Check ALL that apply)
___ spells of spinning and nausea.
___ off-balance sensation without dizziness
___ a light-headed or near faint sensation.
___ other. Please explain. _____
_____

Between episodes I feel . . . (Check ONE)
___ dizzy or off balance all the time.
___ normal.
___ other. Please explain._____
_____

My episodes occur . . . (Check ALL that apply)
___ spontaneously. Nothing I do seems to bring them on or turn them off.
___ only when standing or walking.
___ in relation to any head motion.
___ in relation to only certain head positions. Please describe. _____
_____

When I roll over in bed . . . (Check ONE)
___ nothing unusual happens.
___ the room seems to spin sometimes.
___ the room spins every time.

Dizziness Questionnaire

Is there anything that you can do to make your dizziness go away? (sit, lay down, close eyes . .)
Please explain: _____

_____

Circle all that apply:

I have hearing difficulty . . . . . .Right . . . . . Left . . . . . .Both
I have ringing or other sounds in my ear . . . . . Right . . . . . Left . . . . . .Both
I have a feeling of fullness in my ear . . . . . .Right . . . . . Left . . . . . .Both
I have had ear surgery . . . . . .Right . . . . . Left . . . . . .Both

Circle YES or NO

Did you have a cold, flu, or virus type system shortly before the onset of your dizziness?	YES / NO
Did you fly in a plane, swim under water, or have a head trauma shortly before the onset of your dizziness?	YES / NO
If you had head trauma prior to your dizziness, did you lose consciousness completely?	YES / NO
Were you exposed to any irritating fumes, paints, etc. at the onset of your dizziness?	YES / NO
Did you get new glasses recently?	YES / NO
Are you under a great deal of stress?	YES / NO

In the past year I have had . . . (Check ALL that apply)

___ loss of consciousness
___ seizures or convulsions
___ slurring of speech
___ difficulty swallowing
___ weakness in one hand, arm, or leg
___ double vision
___ spots before the eyes
___ occasional loss of vision
___ severe pounding headache or migraine
___ palpitations of the heartbeat
___ tingling around the mouth
___ tendency to fall
___ loss of balance when walking

I have or have had. . . (Check ALL that apply)

___ Diabetes
___ High blood pressure
___ Arthritis
___ Irregular heartbeat
___ Stroke
___ Migraine headaches
___ A neck and/or back injury
___ Allergies

Please check below for any MEDICATIONS you have tried or are currently taking for dizziness:

	Taken in past	Taking now
Antivert (meclizine)	____	____
Valium (diazepam)	____	____
Dyazide "water pills"	____	____

Have you ever been previously evaluated for dizziness?

_____

_____