



## QUESTIONNAIRE

### Dizziness History Questionnaire

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

**WHEN** was the first time you ever had dizziness? \_\_\_\_\_

**WHAT** were the circumstances? \_\_\_\_\_

**WHEN** was the last time you experienced dizziness? \_\_\_\_\_

**WHAT** were the circumstances? \_\_\_\_\_

### CURRENTLY MY DIZZINESS...

- is constant
- is always there, but changes in intensity
- comes in episodes.

### IF 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

### MY DIZZINESS MOSTLY CONSISTS OF ...(Check ALL that apply)

- spells of spinning with nausea.
- off-balance sensation.
- 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.
- Only in certain head position. Please describe \_\_\_\_\_

### WHEN I ROLL OVER IN BED ... (Check ONE)

- Nothing usually happens.
- The room seems to spin sometimes.

### IS THERE ANYTHING THAT YOU CAN DO TO MAKE YOUR DIZZINESS GO AWAY?

(sit, lay down, close eyes...)

Please explain: \_\_\_\_\_

**QUESTIONNAIRE**

**CIRCLE ALL THAT APPLY:**

I have hearing difficulty *Right / Left / Both*  
I have ear fullness *Right / Left / Both*

I have ringing or other sound *Right / Left/ Both*  
I have had ear surgery *Right / Left / Both*

**CIRCLE YES OR NO**

- Did you have a cold, flu or virus type symptoms shortly before the onset of your dizziness?..... **YES/NO**
- Did you cough, lift, sneeze, fly in a plane, swim under water or have ahead trauma shortly before the onset of your dizziness?.....**YES/NO**
- Were you exposed to any irritating fumes, paints, etc. at the onset of your dizziness? .....**YES/NO**
- Do you get dizzy when you have not eaten for a long time? .....**YES/NO**
- Is your dizziness connected with your menstrual period? .....**YES/NO**
- Did you get new glasses recently?.....**YES/NO**
- I considered myself to be an anxious or tense type of person ..... **YES/NO**

**IN THE PAST YEARS I HAVE HAD .. (CHECK ALL THAT APPLY)**

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

**I HAVE OR HAVE HAD.. (CHECK ALL THAT APPLY)**

- Diabetic    Stoke    High blood pressure    Migraine headaches    Arthritis
- A neck and/or back injury    Irregular heartbeat    Allergies

**PLEASE CHECK BELOW FOR ANY MEDICATIONS YOU HAVE TRIED FOR DIZZINESS OR ARE CURRENTLY TAKING:**

	Taken in past	Taking now	Helps
Antivert (Meclizine)	_____	_____	_____
Valium (Diazepam)	_____	_____	_____
Dyazide water pills	_____	_____	_____

**HAVE YOU EVER BEEN PREVIOUSLY EVALUATED FOR DIZZINESS?**

Where? When? \_\_\_\_\_  
\_\_\_\_\_