# Dizziness Questionnaire

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age:</td>
<td>Date of Birth:</td>
</tr>
<tr>
<td>Gender:</td>
<td>Male / Female</td>
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</tbody>
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1) What term(s) best describe your “dizziness?”
- Spinning sensation – the room / your body
- Feeling off balance
- Lightheaded
- Other ________________________________
- Sensation of falling
- Nearly passing out

2) When did your episode **first** occur? ________________
- How long did it last? _____ Minutes _____ Hours _____ Days _____Constant
- Has it changed since then? YES / NO
- Stronger
- Weaker
- More frequent
- Less frequent

3) When you try to walk, do you stumble to the  □ Right or □ Left?

4) When was your **last** episode? ________________
- How often do your episodes occur? _____ Minutes _____ Hours _____ Days
- How long does each episode last?
  - Few seconds
  - Seconds to minutes
  - Minutes to hours
  - Hours to days

5) During your episodes do you experience any of the following:
- Ear fullness
- Noise or ringing in your ears
- Hearing loss
- Change in hearing
- Ear pain
- Memory loss
- Nausea or vomiting
- Visual blurring
- Headaches
- Falling
- Double vision
- Facial numbness
- Passing out
- Loss of vision
- Anxiety attack
- Difficulty talking
- Difficulty breathing
- Other ________________________________

6) What triggers or worsens your dizziness?
- Standing or sitting up
- Turning over in bed
- Lying down
- Head movement
- Nothing triggers it
- Other ________________________________
- Hormonal changes
- Stress

7) What makes your dizziness better?
- Not moving
- Opening my eyes
- Eating / Drinking
- Medications
- Other ________________________________

8) Have you changed any medications near the time your dizziness started?
   NO / YES

9) Have you or are you currently taking any of the following medications for dizziness:
- Meclizine / Antivert
- Valium
- Dyazide / Water pills
- Do they help decrease your dizziness? YES / NO

***** Continued on Next Page *****
10) Do you have a history of any of the following: (if yes, please describe)

- ☐ Epilepsy / Seizures
- ☐ Heart problems
- ☐ Migraine Headaches
- ☐ Head or Neck injuries
- ☐ Loss of Consciousness
- ☐ Cancer or Chemotherapy
- ☐ IV Antibiotics
- ☐ Emotional / Psychiatric problems
- ☐ Strokes
- ☐ AIDS
- ☐ Blood Vessel Narrowing
- ☐ Vision Problems
- ☐ Ear Infections
- ☐ Ear Surgery
- ☐ Loss of Bowel or Bladder Control
- ☐ Paralysis or Loss of Feeling in the Body

11) Do you have a family history of any of the following:

- ☐ Hearing loss
- ☐ High blood pressure
- ☐ Asthma
- ☐ Dizziness
- ☐ Low blood pressure
- ☐ Allergies
- ☐ Thyroid problems
- ☐ Hypoglycemia
- ☐ Anxiety disorder
- ☐ Diabetes

12) Have you had any of the following:

- ☐ Prior evaluation for dizziness
- ☐ Evaluation by an ENT Physician
- ☐ 24 hour Holter monitor
- ☐ Head MRI / CT scan
- ☐ Carotid Doppler
- ☐ ENG (balance test)
- ☐ Hearing Evaluation
- ☐ Other

13) How would you describe your hearing:

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

HEARING (Better in RIGHT / LEFT)

14) Do you usually have ear noises (tinnitus)? YES / NO

- ☐ Right
- ☐ Left
- ☐ Both

(Worse in RIGHT / LEFT)

EXTRA INFO

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________