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| **DIZZINESS QUESTIONNAIRE** | | |
| **PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BIRTH DATE: \_\_\_\_\_\_\_\_\_ TODAY’s DATE: \_\_\_\_\_\_\_\_\_** | | |
| Equilibrium disorders may appear with a variety of symptoms. Some individuals may experience dizziness or vertigo while others may have imbalance or unsteadiness. Please spend a few minutes answering, to the best of your ability, the questions regarding your history and symptoms. | | |
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| How or when did your problem first occur? | | |
| How long did it last? | | |
| 1. **Do you experience any of the following sensations? Please read the entire list first, then check either YES or NO to describe your feeling most accurately.** | | |
| YES | NO |  |
| \_\_\_\_\_ | \_\_\_\_\_ | Do you experience motion sickness, airsickness or seasickness? |
| \_\_\_\_\_ | \_\_\_\_\_ | Did you have motion sickness as a child? |
| \_\_\_\_\_ | \_\_\_\_\_ | Do you have a family history of motion sickness? Parent\_\_\_? Sibling\_\_\_? Child\_\_\_? |
| \_\_\_\_\_ | \_\_\_\_\_ | Do you have migraine headaches? |
| \_\_\_\_\_ | \_\_\_\_\_ | Were you exposed to any solvents, chemicals, etc.? |
| \_\_\_\_\_ | \_\_\_\_\_ | Did you have any injuries to your head? When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_ | \_\_\_\_\_ | If you received a head injury, were you unconscious? |
| \_\_\_\_\_ | \_\_\_\_\_ | Have you ever had a neck injury? |
| \_\_\_\_\_ | \_\_\_\_\_ | Have you ever fallen? How many times? \_\_\_\_ Where? \_\_\_\_ Inside the home? \_\_\_\_\_\_\_  Outside the home? \_\_\_\_\_\_ |
| \_\_\_\_\_ | \_\_\_\_\_ | Are you afraid of falling? |
| \_\_\_\_\_ | \_\_\_\_\_ | Do you take any medications regularly? (i.e. tranquilizers, oral contraceptives, barbiturates, antibiotics, thyroid). What?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_ | \_\_\_\_\_ | Do you use alcohol? |
| 1. **If you have dizziness, please check either YES or NO, and fill in the blank spaces. If you do not experience dizziness, please go to the next section (III).** | | |
| YES | NO |  |
| \_\_\_\_\_ | \_\_\_\_\_ | My dizziness is constant? If you answered YES, please go to section III. If in attacks,  how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_ | \_\_\_\_\_ | Are you completely free of dizziness between attacks? |
| \_\_\_\_\_ | \_\_\_\_\_ | Do you have any warning that the attack is about to start? |
| \_\_\_\_\_ | \_\_\_\_\_ | Is the dizziness provoked head/body movement? If so, which direction? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_ | \_\_\_\_\_ | Is the dizziness better or worse at any particular time of the day?  If so, when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_ | \_\_\_\_\_ | Do you know of anything, that will stop your dizziness or make it better?  What? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_ | \_\_\_\_\_ | Do you know of anything that will make your dizziness worse?  What? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_ | \_\_\_\_\_ | Do you know of anything that will precipitate an attack?  What? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_ | \_\_\_\_\_ | Do you know any possible cause of your dizziness?  What? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| 1. **Do you experience any of the following sensations? Please read the entire list first then check YES or NO to describe your feelings most accurately.** | | | | | | | |
| YES | NO |  | | | | | |
| \_\_\_\_\_ | \_\_\_\_\_ | Light headedness? | | | | | |
| \_\_\_\_\_ | \_\_\_\_\_ | Swimming sensation in the head? | | | | | |
| \_\_\_\_\_ | \_\_\_\_\_ | Blacking out or loss of consciousness? | | | | | |
| \_\_\_\_\_ | \_\_\_\_\_ | Objects spinning or turning around you? | | | | | |
| \_\_\_\_\_ | \_\_\_\_\_ | Sensation that you are turning or spinning inside, with outside objects remaining stationary? | | | | | |
| \_\_\_\_\_ | \_\_\_\_\_ | Tendency to fall to the right or left? | | | | | |
| \_\_\_\_\_ | \_\_\_\_\_ | Tendency to fall forward or backward? | | | | | |
| \_\_\_\_\_ | \_\_\_\_\_ | Loss of balance when walking --- Veering to the right? | | | | | |
| \_\_\_\_\_ | \_\_\_\_\_ | Loss of balance when walking --- Veering to the left? | | | | | |
| \_\_\_\_\_ | \_\_\_\_\_ | Do you have trouble walking in the dark? | | | | | |
| \_\_\_\_\_ | \_\_\_\_\_ | Do you have problems turning to one side or the other? | | | | | |
| \_\_\_\_\_ | \_\_\_\_\_ | Nausea or vomiting? | | | | | |
| \_\_\_\_\_ | \_\_\_\_\_ | Pressure in the head? | | | | | |
| 1. **Have you ever experienced any of the follow symptoms? Please check YES or NO and circle if CONSTANT or IN EPISODES.** | | | | | | | |
| YES | NO |  | | | | | |
| \_\_\_\_\_ | \_\_\_\_\_ | Double vision? | | Constant | | In Episodes | |
| \_\_\_\_\_ | \_\_\_\_\_ | Blurred vision or blindness? | | Constant | | In Episodes | |
| \_\_\_\_\_ | \_\_\_\_\_ | Spots before your eyes? | | Constant | | In Episodes | |
| \_\_\_\_\_ | \_\_\_\_\_ | Numbness of face, arms or legs? | | Constant | | In Episodes | |
| \_\_\_\_\_ | \_\_\_\_\_ | Weakness in arms or legs? | | Constant | | In Episodes | |
| \_\_\_\_\_ | \_\_\_\_\_ | Confusion or loss of consciousness? | | Constant | | In Episodes | |
| \_\_\_\_\_ | \_\_\_\_\_ | Difficulty in swallowing? | | Constant | | In Episodes | |
| \_\_\_\_\_ | \_\_\_\_\_ | Tingling around the mouth? | | Constant | | In Episodes | |
| \_\_\_\_\_ | \_\_\_\_\_ | Difficulty speaking? | | Constant | | In Episodes | |
| 1. **Do you have any of the following symptoms? Please check YES or NO and circle the ear involved.** | | | | | | | |
| YES | NO |  | | | | | |
| \_\_\_\_\_ | \_\_\_\_\_ | Difficulty in hearing? When did it first start? \_\_\_\_\_\_\_\_\_\_\_\_  Is it getting worse? \_\_\_\_\_\_\_ Does the hearing change with your symptoms? \_\_\_\_\_\_\_ If so, how? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Right | | Left | | Both |
| \_\_\_\_\_ | \_\_\_\_\_ | Noise in your ears?  Describe the noise. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Does the noise change with your symptoms? \_\_\_\_\_\_\_  If so, how? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Right | | Left | | Both |
| \_\_\_\_\_ | \_\_\_\_\_ | Does anything stop the noise or make it better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Right | | Left | | Both |
| \_\_\_\_\_ | \_\_\_\_\_ | Fullness or stuffiness in your ears?  Does this change when you are dizzy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Right | | Left | | Both |
| \_\_\_\_\_ | \_\_\_\_\_ | Pain in your ears? | Right | | Left | | Both |
| \_\_\_\_\_ | \_\_\_\_\_ | Discharge from your ears? | Right | | Left | | Both |