SHOW LOW
2600 S. White Mountain Rd.
Show Low, AZ 85901
Phone: (928) 537-3456
Fax: (928) 537-3469

SAFFORD
620 S Central Ave, Ste B
Safford, AZ 85546
Phone: (928) 428-1613
Fax: (928) 428-0055

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.

How or when did your problem first occur?

How long did it last?

I. 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?

II. 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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III.	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?

IV.	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

V.	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