Dizziness Questionnaire

Patient Name: _____ Date: _____

DIZZINESS HISTORY

WHEN was the first time you ever had dizziness?_____

WHAT were the circumstances? _____

WHEN was the last time you experienced dizziness? _____

Currently, my dizziness …….€ is constant € is always there, but changes in intensity € comes in episodes.

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

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 relations to any head motion.
- € only in certain head positions. Please describe _____

When I roll over in bed…. (Check ONE)

- € nothing unusual happens.
- € the room seems to spin sometimes.

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

HEARING / OTHER HEALTH HISTORY

I have hearing difficulty € Yes € No

If yes, I have difficulty hearing in: Right Ear / Left Ear / Both Ears (Circle one)

If yes, my hearing loss has been present…… € for a long time € since my dizziness began

I have ringing or other sounds Right / Left / Both

I have ear fullness Right / Left / Both

I have had ear surgery Right / Left / Both

I wear hearing aid (s) Right / Left / Both

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

€ loss of consciousness € occasional loss of vision € seizures or convulsions € double vision
€ severe pounding headache or migraine € tendency to fall € slurring of speech € loss of balance

MEDICATIONS

Are you currently taking:

	Taken in the past	Taking now	Last taken	Helps
Antivert (Meclizine)	_____	_____	_____	Yes / No
Valium (Diazepam)	_____	_____	_____	Yes / No
Dyazide “water pills”	_____	_____	_____	Yes / No

Medications taken within the past 48 hours:_____
_____
_____