COLORADO WEST OTOLARYNGOLOGISTS, P.C.
DIZZINESS QUESTIONNAIRE

Date___________________

Name____ Date of birth__________________

I. When you are "dizzy", do you experience any of the following sensations? Please read the entire list first. Then put an "x" in either the first box for YES or the second box for NO to describe your feelings most accurately.

YES	NO		
☐	☐	1. Lightheadedness.	**Blood Pressure**
☐	☐	2. Swimming sensation in the head.	
☐	☐	3. Blacking out.	**1. Sitting**_______________
☐	☐	4. Loss of consciousness	
☐	☐	5. Tendency to fall: To the right?	**2. Lying**_______________
		To the left?	
		Forward?	**3. Standing**_____________
		Backward?	
☐	☐	6. Objects spinning or turning around you.	
☐	☐	7. Sensation that you are turning or spinning inside, with outside objects remaining stationary.	
☐	☐	8. Loss of balance when walking: Veering to the right?	
		Veering to the left?	
☐	☐	9. Headache.	
☐	☐	10. Nausea or vomiting.	
☐	☐	11. Pressure in the head.	

II. Please check boxes for either YES or NO and fill in the blank spaces.

YES	NO	
☐	☐	1. My dizziness is constant?
☐	☐	in attacks?
		2. When did dizziness first occur?____
		3. If in attacks: How often?____
		How long do they last?____
☐	☐	Do you have any warning that the attack is about to start?__________________
☐	☐	4. Are you completely free of dizziness between attacks?
☐	☐	5. Does dizziness occur only in certain positions?
☐	☐	6. Do you have trouble walking in the dark?
☐	☐	7. When you are dizzy, must you support yourself when standing?
☐	☐	8. Do you know of any possible cause of your dizziness? If so, what?____
		9. Do you know anything that will:
☐	☐	Stop your dizziness or make it better?
☐	☐	Make your dizziness worse?
☐	☐	Precipitate an attack?

(continued on back)

YES	NO	
☐	☐	10. Were you exposed to any irritating fumes, paints, etc., at the onset of dizziness?
☐	☐	11. Do you have any allergies?
☐	☐	12. Did you ever injure your head?
☐	☐	Were you unconscious?
☐	☐	13. Do you take any medications regularly? (i.e. tranquilizers, oral contraceptives, barbiturates, antibiotics) What?____________________
☐	☐	14. Do you use tobacco in any form? How much?____________________
☐	☐	15. Do you use alcohol?
☐	☐	16. Have you ever had ear surgery?

III. Do you have any of the following symptoms? Put an "x" in the first box for YES or the second box for NO and circle which ear is involved.

YES	NO		
☐	☐	1. Difficulty in hearing?	**Both ears / Right / Left**
		When did this start?____________________	
☐	☐	2. Noise is your ears?	**Both ears / Right / Left**
		Describe the noise ____________________	
☐	☐	Does the noise change with dizziness? If so, how? ____________________	
☐	☐	3. Fullness or stuffiness in your ears?	**Both ears / Right / Left**
☐	☐	Does this change when you are dizzy?	
☐	☐	4. Pain in your ears?	**Both ears / Right / Left**
☐	☐	5. Discharge in your ears?	**Both ears / Right / Left**

IV. Have you ever experienced any of the following symptoms? Put an "x" in the first box for YES or the second box for NO and circle if constant or if in episodes.

YES	NO			
☐	☐	1. Double vision.	Constant	In Episodes
☐	☐	2. Numbness of face or extremities.	Constant	In Episodes
☐	☐	3. Blurred vision or blindness.	Constant	In Episodes
☐	☐	4. Weakness in arms or legs.	Constant	In Episodes
☐	☐	5. Clumsiness in arms or legs.	Constant	In Episodes
☐	☐	6. Confusion or loss of consciousness.	Constant	In Episodes
☐	☐	7. Difficulty with speech.	Constant	In Episodes
☐	☐	8. Difficulty with swallowing.	Constant	In Episodes
☐	☐	9. Tingling around the mouth.	Constant	In Episodes
☐	☐	10. Spots before the eyes.	Constant	In Episodes

V. Please check box for either YES or NO.

YES	NO	
☐	☐	1. Do you get dizzy after exertion or overwork?
☐	☐	2. Did you get new glasses recently?
☐	☐	3. Do you tend to get upset easily?
☐	☐	4. Do you get dizzy when you have not eaten for a long time?
☐	☐	5. Is your dizziness connected with your menstrual period?
☐	☐	6. Have you ever had a neck injury?