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Patient Name: _____

Date: _____

DIZZINESS QUESTIONAIRE

Please answer all of the following questions by checking the appropriate responses or by filling in relevant blanks.

CHARACTERIZE YOUR DIZZINESS

1. Lightheadedness, fainting, giddiness. ☐ Yes ☐ No
2. Unsteadiness. ☐ Yes ☐ No
3. I or my surroundings seem to be moving. ☐ Yes ☐ No
4. I am able to go on with my usual activities while dizzy. ☐ Yes ☐ No
5. I am able to go on with only some of my usual activities while dizzy. ☐ Yes ☐ No
6. I am completely incapacitated and must go to bed while dizzy. ☐ Yes ☐ No

ONSET AND COURSE

7. Date of first dizziness _____
8. My dizziness is constant. ☐ Yes ☐ No
9. My dizziness comes in attacks. ☐ Yes ☐ No
   a. If in attacks, how often? ☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly
   b. How long do they last? ☐ Seconds ☐ Minutes ☐ Hours ☐ Days
10. My dizziness comes on suddenly. ☐ Yes ☐ No
11. My dizziness comes on gradually. ☐ Yes ☐ No
12. I am completely free of dizziness between attacks. ☐ Yes ☐ No
13. I can tell when an attack is about to start. Describe how: _____

_____

ASSOCIATED SYMPTOMS

14. Nausea or vomiting? ☐ Yes ☐ No
15. Sweating? ☐ Yes ☐ No
16. Deafness or difficulty hearing? ☐ Right ear ☐ Left ear ☐ Both ears
17. Any noises (buzzing or ringing in the ears)? ☐ Right ear ☐ Left ear ☐ Both ears
18. Any change in this noise with dizziness? ☐ Yes ☐ No
19. Fullness or pain in ears? ☐ Right ear ☐ Left ear ☐ Both ears
20. Drainage from ears? ☐ Right ear ☐ Left ear ☐ Both ears
21. Tendency to fall? ☐ Right ☐ Left ☐ Either
22. Tendency to veer when walking? ☐ Right ☐ Left ☐ Either

23. Headache or pressure in head? ☐ During ☐ After ☐ None
    Where? _____
24. Weakness or clumsiness in arms or legs? ☐ Yes ☐ No
25. Difficulty with speech or swallowing? ☐ Yes ☐ No
26. ☐ Blackouts? ☐ Loss of consciousness? ☐ Confusion? ☐ Loss of memory?
27. ☐ Rapid heartbeat/palpitations? ☐ Double Vision? ☐ Blurred Vision? ☐ Blindness?
28. Shortness of breath during the attack? ☐ Yes ☐ No
29. Numbness or tingling of face, fingers or toes? ☐ Yes ☐ No
30. Pain or stiffness of the neck? ☐ Yes ☐ No

EXACERBATING AND REMITTING FACTORS

31. Does turning your head bring on or make your dizziness worse? ☐ Yes ☐ No
    Which direction? _____
32. Does lying down or sitting up bring on your dizziness? ☐ Yes ☐ No
33. Does standing up bring on your dizziness? ☐ Yes ☐ No
34. Do you find it especially difficult to walk in the dark? ☐ Yes ☐ No
35. Is there any relationship between your dizziness and
    tension or anxiety in your life? ☐ Yes ☐ No
    If yes, Explain _____
36. Do you know of anything that will precipitate an attack? ☐ Yes ☐ No
    What? _____
37. Is there anything that will stop or make your dizziness better?
    What? _____

PRESENT/PAST MEDICAL HISTORY

38. Have you ever had a concussion, skull fracture or been knocked unconscious? ☐ Yes ☐ No
39. Have you ever had a whiplash or do you have a neck disease? ☐ Yes ☐ No
40. Do you have an eye disorder or wear glasses? ☐ Yes ☐ No
41. Have you ever had ear infections or other ear disease? ☐ Yes ☐ No
42. Had you been taking prescription or nonprescription medications
    regularly before your dizziness started? ☐ Yes ☐ No
    If yes, list them _____
    _____
43. Do you have allergies? To what? _____
44. Have you in the past or do you currently smoke? ☐ Yes ☐ No
    Packs per day _____ How many years? _____
45. Have you been in the past or are you now a heavy drinker? ☐ Yes ☐ No
46. Have you in the past or do you now have:
    ☐ Diabetes ☐ High Blood Pressure ☐ Migraines ☐ Seizures ☐ Cancer ☐ Stroke ☐ Heart Attack
47. Do you know of any possible cause of your dizziness? ☐ Yes ☐ No
    What? _____
48. Has another doctor performed tests to evaluate your dizziness? ☐ Yes ☐ No
    Dr. _____ Phone (_____)_____ Date _____
49. Do you wear an intracardiac catheter or pacemaker with exposed leads? ☐ Yes ☐ No