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Dizziness Questionnaire

Name:		**Date:**
Age:	**Date of Birth:**	**Gender:** **Male / Female**

1) What term(s) best describe your "dizziness" or "imbalance"?

- ☐ Spinning sensation – the room / your body
- ☐ Feeling off balance
- ☐ Lightheaded
- ☐ Other ____________________
- ☐ Sensation of falling
- ☐ Nearly passing out

2) When did your episode FIRST occur? ____________________

How long did it last? _____ Minutes _____ Hours _____Days _____Constant

Has it changed since it first started? ☐ YES ☐ NO

How has it changed? ☐ Stronger ☐ Weaker ☐ More frequent ☐ Less frequent

3) When you try to walk, do you stumble to the ☐ Right or ☐ Left?

4) When was your LAST episode? ____________________

How OFTEN do your episodes occur? _______ Minutes _______ Hours _______ Days

How LONG does each episode last?

☐ Few seconds ☐ Seconds to minutes ☐ Minutes to hours ☐ Hours to days

5) DURING your episodes of dizziness or imbalance, do you experience any of the following:

- ☐ Ear fullness
- ☐ Noise or ringing in your ears
- ☐ Hearing loss
- ☐ Change in hearing
- ☐ Ear pain
- ☐ Memory loss
- ☐ Nausea or vomiting
- ☐ Visual blurring
- ☐ Headaches
- ☐ Falling
- ☐ Double vision
- ☐ Facial numbness
- ☐ Passing out
- ☐ Loss of vision
- ☐ Anxiety attack
- ☐ Difficulty talking
- ☐ Difficulty breathing
- ☐ Other ____________________

6) What triggers or worsens your dizziness or imbalance?

- ☐ Standing or sitting up
- ☐ Lying down
- ☐ Nothing triggers it
- ☐ Other ____________________
- ☐ Turning over in bed
- ☐ Head movement
- ☐ Hormonal changes
- ☐ Stress

7) What makes your dizziness or imbalance better?

☐ Not moving ☐ Opening my eyes ☐ Eating or Drinking ☐ Sleeping

☐ Medications ____________________ ☐ Other ____________________

8) Have you changed any medications near the time your dizziness or imbalance started?

☐ NO ☐ YES Medication Name: ____________________

9) Have you or are you currently taking any of the following medications for dizziness or imbalance:

☐ Meclizine / Antivert ☐ Valium ☐ Dyazide / Water pills

Do these medications decrease your dizziness? ☐ YES ☐ NO

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10) Do you have a history of any of the following: *(if yes, please describe)*

- ☐ Epilepsy / Seizures ____________________
- ☐ Heart problems ____________________
- ☐ Migraine Headaches ____________________
- ☐ Head or Neck injuries ____________________
- ☐ Loss of Consciousness ____________________
- ☐ Cancer or Chemotherapy ____________________
- ☐ IV Antibiotics ____________________
- ☐ Emotional / Psychiatric problems ____________________
- ☐ Strokes ____________________
- ☐ AIDS ____________________
- ☐ Blood Vessel Narrowing ____________________
- ☐ Vision Problems ____________________
- ☐ Ear Infections ____________________
- ☐ Ear Surgery ____________________
- ☐ Loss of Bowel or Bladder Control ____________________
- ☐ Paralysis or Loss of Feeling in the Body ____________________

11) Do you have a FAMILY HISTORY of any of the following:

- ☐ Hearing loss
- ☐ Dizziness
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hypoglycemia
- ☐ Asthma
- ☐ Allergies
- ☐ Anxiety disorder

12) Have you had any of the following performed:

- ☐ Prior evaluation for dizziness ____________________
- ☐ Evaluation by an ENT Physician ____________________
- ☐ 24 hour Holter monitor ____________________
- ☐ Head MRI / CT scan ____________________
- ☐ Carotid Doppler ____________________
- ☐ ENG (balance test) ____________________
- ☐ Hearing Evaluation ____________________
- ☐ Other ____________________

13) How would you describe your HEARING:

☐ Excellent ☐ Good ☐ Fair ☐ Poor Better in ☐ RIGHT or ☐ LEFT

14) Do you usually have EAR NOISES (tinnitus)? ☐ YES ☐ NO

☐ Right ☐ Left ☐ Both Worse/Louder in ☐ RIGHT or ☐ LEFT

EXTRA INFO ____________________

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