Patient name_____ Date_____

# DIZZINESS QUESTIONAIRE

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

## CHARACTERIZE YOUR DIZZINESS

Yes No 1. Lightheadedness, faintness, giddiness.
Yes No 2. Unsteadiness.
Yes No 3. My surroundings or I 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.

## ONSET AND COURSE

7. Date of first dizziness_____
Yes No 8. My dizziness is constant.
Yes No 9. My dizziness comes in attacks.
10. If in attacks, how often? hourly daily weekly monthly
11. How long do they last? seconds minutes hours days
Yes No 12. My dizziness comes on suddenly.
Yes No 13. My dizziness comes on gradually.
Yes No 14. I am completely free of dizziness between attacks.
Yes No 15. I can tell when an attack is about to start.
Describe how_____

## ASSOCIATED SYMPTOMS

Yes No 16. Nausea or vomiting?
Yes No 17. Sweating?
Yes No 18. Deafness or difficulty hearing? right ear left ear both ears
Yes No 19. Any noises (buzzing or ringing in ears)? right ear left ear both ears
Yes No 20. Change in this noise with dizziness?
Yes No 21. Fullness or pain in ears? right ears left ears both ears
Yes No 22. Drainage from ears? right ear left ear both ears
Yes No 23. Tendency to fall? right left either
Yes No 24. Tendency to veer when walking? right left either
Yes No 25. Headache or pressure in head? during after
Where?_____
Yes No 26. Double vision, blurred vision or blindness?
Yes No 27. Weakness or clumsiness in arms or legs?
Yes No 28. Difficulty with speech or swallowing?
Yes No 29. Blackouts, loss of consciousness, confusion or loss of memory?
Yes No 30. Rapid heartbeat or palpitations?
Yes No 31. Shortness of breathe during the attack?
Yes No 32. Numbness or tingling of face, fingers or toes?
Yes No 33. Pain or stiffness of the neck?

## EXACERBATING AND REMITTING FACTORS

Yes No 34. Does turning your head bring on or make your dizziness worse?
Which direction?_____

Yes No 35. Does lying down or sitting up bring on your dizziness?
Yes No 36. Does standing up bring on your dizziness?
Yes No 37. Do you find it especially difficult to walk in the dark?
Yes No 38. Is there any relationship between your dizziness and tension or anxiety in your life? Explain:_____
Yes No 39. Do you know of anything that will precipitate an attack? What?_____
Yes No 40. Do you know of anything that will stop or make your dizziness better? What?_____

**PRESENT/PAST MEDICAL HISTORY**

Yes No 41. Have you ever had a concussion, skull fracture, or been knocked unconscious?
Yes No 42. Have you ever had a whiplash or do you have a neck disease?
Yes No 43. Do you have an eye disorder or wear glasses?
Yes No 44. Have you ever had ear infections or other ear disease?
Yes No 45. Had you been taking prescription or nonprescription medications regularly before your dizziness started? If so, list them._____
Yes No 46. Do you have any allergies? To what?_____
Yes No 47. Have you in the past or do you now smoke? Packs per day_____ Years_____
Yes No 48. Have you in the past or are you now a heavy drinker?
Yes No 49. Have you in the past or do you now have: diabetes high blood pressure migraine seizures cancer stroke heart attack
Yes No 50. Do you know of any possible cause of your dizziness? What._____
Yes No 51. Has another doctor done tests to evaluate your dizziness? Dr. _____Phone_____Date_____
Yes No 52. Do you wear an intracardiac catheter or pacemaker with exposed leads?