Dizziness Questionnaire

The patient history and a description of the symptoms are extremely important in making a correct diagnosis. Please answer yes or no, circle the appropriate answer, or fill in the appropriate blanks for EACH QUESTION.

1. Describe your dizziness symptoms.
   ___Yes  ___No  a) Spinning vertigo
   ___Yes  ___No  b) Lightheadedness/wooziness
   ___Yes  ___No  c) Imbalance/trouble walking/trouble standing
   ___Yes  ___No  d) Veering or falling:   ____To the right  ____To the left  ____Forward  ____Backward
   ___Yes  ___No  e) Delayed focusing of visual fields
   ___Yes  ___No  f) Visual blurring during head motion
   ___Yes  ___No  g) Blacking out   (If yes, do you lose consciousness? ___Yes  ___No)

**Duration, Timing, Context and Severity**

2. When was your first dizzy episode? (date) ____________________________
3. When did the most recent dizziness episode begin? (Date) ____________________________
4. Is the dizziness constant or recurrent?   ____Constant  ____Recurrent  ____Constant when walking
5. How long do the episodes last?   ____________________________ (circle)  ... Seconds  Minutes  Hours  Days
6. How often do the episodes occur?   ____________________________ per (circle)  ... Day  Week  Month  Year
7. Rate the severity of the dizziness. (10 is the MOST severe)   _______________
8. Is the dizziness:  (Circle)  Improving  Getting worse  The same

**Modifying Factors**

9. ___Yes  ___No  Is the dizziness triggered by rapid movements of the head or body? (If yes, circle those that apply)
   All rapid head movements  Lying down  Looking up  Bending over  Rising  Getting out of bed
   Turning head to the right  Turning head to the left  Rolling right in bed  Rolling left in bed
10. Do any of the following trigger the dizziness? (If yes, circle those that apply)
    Caffeine  Salt  Other dietary items  Stress  Fatigue  Emotional changes  Allergies  Automobile rides

**Other ____________________________________________

11. What, if anything, makes your dizziness better? (list) _______________________________
12. ___Yes  ___No  Have you experienced motion sickness?
13. ___Yes  ___No  Do you have problems walking in the dark?
14. ___Yes  ___No  Do you require assistance when walking?  Sometimes/Always  (Circle those that apply)  Companion  Cane  Walker
15. ___Yes  ___No  Did you suffer a cold, flu, or other infectious symptoms at the time your dizziness began?
16. ___Yes  ___No  Have you suffered:  (Circle those that apply)  Head trauma  Concussion  Stroke  TIA (mini-stroke)

**Assorted Signs and Symptoms**

17. ___Yes  ___No  Do you experience increased ear ringing with each dizzy spell? …… Which ear?  ____Right  ____Left
18. ___Yes  ___No  Do you suffer increased hearing loss with each dizzy spell? …… Which ear?  ____Right  ____Left
19. ___Yes  ___No  Do you suffer increased ear pressure in your ears with each dizzy spell? … Which ear?  ____Right  ____Left
20. ___Yes  ___No  Do you experience nausea or vomiting with the dizzy spells?  (Circle)  Nausea  Vomiting
21. ___Yes  ___No  Have you experienced falls?
22. ___Yes  ___No  Do you suffer from recurrent headaches or pressure in the head?  Location: __________________________________________
23. ___Yes  ___No  Do the headaches occur at the same time as the dizziness?
24. Are your headaches associated with any of the following symptoms? (Please circle all that apply)
   Throbbing head pain  Moderate or severe head pain  Visual spots/ Squiggly lines
   Sensitivity to bright lights  Sensitivity to loud noises  Nausea  Vomiting

25. ___Yes  ___No  Have you seen any other doctors for evaluation of this problem? (Provide name) _________________________________
26. ___Yes  ___No  Have you been diagnosed with a specific ear or balance problem? _________________________________
27. ___Yes  ___No  Have you had other tests completed?  (If yes, circle all those that apply.)
   Hearing Test  Vestibular/Balance testing  MRI scan of the brain  CT scan of the brain  Carotid ultrasound  Heart Testing

Name (print): ____________________________________________ Signature: ____________________________ Date: ______________
S:\FORMS\Front Desk\New Patient Packet\Dizziness Questionnaire  Update 9.29.2016