



Patient Name: _____ DOB: _____ Date: _____

The following questions refer to your feeling of dizziness. Please answer them as “yes” or “no” and fill in all blanks.

Please describe, in your own words, the sensation you feel without using the word “dizzy”.

I. Do you have any of the following sensations?

- Yes.....Spinning in circles.....No
Yes.....Falling to one side.....No
Which side do you fall? _____
Yes.....World Spinning around you.....No

II. The following refer to a typical dizzy spell:

- Yes.....Do the dizzy spells come in attacks?.....No
How often? _____
How long? _____
Date of first spell? _____
Yes.....Are you free from dizziness between attacks?.....No
Yes.....Does your hearing change with an attack?.....No
Yes.....Are you dizzy mainly when you sit or stand up quickly.....No
Yes.....Are you more dizzy in certain positions?.....No
Which position? _____
Yes.....Are you nauseated during an attack?.....No
Yes.....Are you sensitive to light when you are dizzy?.....No
Yes.....Are you dizzy even when laying down?.....No
Yes.....Have you had a recent cold or flu preceding recent dizzy spells?.....No
Yes.....Have you had fullness, pressure or ringing in your ears?.....No
Yes.....Have you had pain or discharge in your ear recently?.....No
Yes.....Have you had trouble walking in the dark?.....No
Yes.....Are you better if you sit or lie perfectly still?.....No

Patient Name: _____ DOB: _____ Date: _____

III. The following refer to other sensations you may have:

- Yes.....Do you black out or faint when dizzy?.....No
- Have you had:
- Yes.....Severe or recurrent headaches.....No
- Yes.....Light sensitivity or nausea with a headache?.....No
- Yes.....Any double or blurry vision?.....No
- Yes.....Numbness in your face or extremities?.....No
- Yes.....Weakness or clumsiness in arms, legs?.....No
- Yes.....Slurred or difficult speech?.....No
- Yes.....Difficulty swallowing?.....No
- Yes.....Tingling around your mouth?.....No
- Yes.....Spots before your eyes?.....No
- Yes.....Jerking of arms or legs?.....No
- Yes.....Seizures?.....No
- Yes.....Confusion or memory loss?.....No
- Yes.....Recent head trauma?.....No

If yes, please explain: _____

IV. The following refer to your hearing. Indicate which side has been affected:

- Yes.....Difficulty hearing?.....Left.....Right.....Both.....No
- Yes.....Ringing in the ear(s)?.....Left.....Right.....Both.....No
- Yes.....Fullness in the ear(s)?.....Left.....Right.....Both.....No
- Yes.....Do loud sound make you dizzy?.....Left.....Right.....Both.....No
- Have you had any of the following?
- Yes.....Pain in the ears?.....Left.....Right.....Both.....No
- Yes.....Discharge from ears?.....Left.....Right.....Both.....No
- Yes.....Hearing change when dizzy?.....No
- Better?.....Left.....Right.....Both
- Worse?.....Left.....Right.....Both
- Yes.....Exposure to loud noise?.....No
- Yes.....Previous ear infections?.....No
- Yes.....Previous ear surgery?.....No
- If yes, what? _____
- Yes.....Family history of deafness?.....No

Patient Name: _____ DOB: _____ Date: _____

V. The following refer to habits and lifestyle:

Yes.....Is there added stress in your life recently?.....No

Yes.....Are you dizzy or unsteady constantly?.....No

Is your dizziness related to:

Yes.....Moments of stress?.....No

Yes.....Menstral period?.....No

Yes.....Overwork or exertion?.....No

Yes.....Do you feel lightheaded or have a swimming sensation when you are dizzy?...No

Yes.....Do you find yourself breathing faster or deeper when excited or dizzy?.....No

Yes.....Did you recently change eyeglasses?.....No

Yes.....Have you ever had weakness or faintness a few hours after eating?.....No

Do you have anything else to add that we have not asked you about on this questionnaire?
