DIZZINESS QUESTIONNAIRE

Patient Name: ______________________ Date: __________________

You have indicated you have vertigo, imbalance or dizziness problems. Answer the following questions by circling the appropriate bold response or answering in the blank space provided.

1. Which of the following most closely resembles your problem? Mark as many as apply.

- ☐ A whirling or spinning sensation where your surroundings, you, or both move.
- ☐ Imbalance without a sensation of motion that:
  - ☐ Causes a rocking sensation.
  - ☐ Makes you feel like you veer or are pushed to one side.
  - ☐ Makes you feel like you need extra support.
- ☐ A sense of lightheadedness, giddiness, head swimming, floating.
- ☐ None of the above, more like________________________________.

2. I have dizziness ☐ all of the time / ☐ some of the time / ☐ once in a while.
Symptoms are ☐ constant / ☐ fluctuate.

3. I ☐ have / ☐do not have isolated attacks of vertigo that come________ times a ☐ week / ☐ month / ☐ year.

4. When attacks occur, the sensation of motion lasts on the average ☐ minutes / ☐hours / ☐days. It takes __________ ☐minutes / ☐hours / ☐days for me to completely regain my balance after the motion ceases.

5. My first attack occurred________________. My most recent attack occurred________________.

6. I ☐can / ☐cannot tell an attack is about to begin. If you can tell, how far ahead can you tell__________.?

7. When my balance disturbance is disturbed, I have: (*please circle*)

☐Ear Ringing	☐Ear Fullness	☐Ear Pressure	☐Hearing Changes
☐Sound Distortion	☐ Headache	☐Visual Changes	☐Numbness/Tingling
☐Darkening	☐Vision Ear Pain	☐Ear Discharge	☐Nausea Vomiting
☐Problem Working	☐Difficulty Walking	☐Unconsciousness	☐Falling

Other: ______________________________

8. What triggers dizziness:____.

9. What makes it worse: ____.

10. What makes it better: ____.

11. My dizziness seems / does not seem to be worse at a particular time of year.

12. Certain foods do / do not trigger or exacerbate my symptoms.

13. Number of MD's seen:_____ Family MD/Internal Medicine _____Neurologist ______ENT/Ear Specialist

Please give additional information about any of the following tests that you have had.

Test Type	Date/Result	Test Type	Date/Result
CT Scans		Audiogram	
MRI scan		ENG	
Ultraound		ABR	
Posturography		EcoG	