ENT & Audiology Center of Southlake

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Otolaryngology-Head and Neck Surgery

DIZZINESS QUESTIONNAIRE

NAME: _____ DOB: _____
DATE: _____ID: _____

CHARACTERIZE YOUR DIZZINESS

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

ONSET AND COURSE

7.	Date of first dizziness episode: _____		
8.	My dizziness is constant.	Yes	No
9.	My dizziness comes in attacks.	Yes	No
10.	If in attacks, how often? Hourly Daily Weekly Monthly		
11.	How long do they last? Seconds Minutes Hours Days		
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.	Yes	No
	Describe how: _____		
16.	I can provoke my dizziness with movement or position.	Yes	No

ASSOCIATED SYMPTOMS

17.	Nausea or vomiting?	Yes	No
18.	Sweating?	Yes	No
19.	Deafness or difficulty hearing? Right ear Left ear Both ears		No
20.	Any noises (buzzing or ringing in ears)? Right ear Left ear Both ears		No
21.	Any change in this noise with dizziness episodes?	Yes	No
22.	Fullness or pain in ears? Right ear Left ear Both ears		No
23.	Drainage from ears? Right ear Left ear Both ears		No
24.	Tendency to fall? Right Left Either		No
25.	Tendency to veer when walking? Right Left Either		No
26.	Headache or pressure in head? ` During After		No
	If so, where: _____		
27.	Circle all that apply:		
	1) Double vision 2) Blurred vision 3) Blindness 4) Tunnel vision		
	5) Blind spots 6) Flashing lights in visual field		
28.	Weakness or clumsiness in arms or legs?	Yes	No
29.	Difficulty with speech or swallowing?	Yes	No
30.	Circle all that apply:		
	1) Blackouts 2) Loss of consciousness 3) Confusion 4) Memory loss		

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31.	Rapid heartbeat or palpitations?	Yes	No
32.	Shortness of breath during the attack?	Yes	No
33.	Numbness or tingling of face, fingers or toes?	Yes	No
34.	Pain or stiffness of the neck?	Yes	No

EXACERBATING AND REMITTING FACTORS

35.	Is the dizziness better with eyes open or closed? (Circle one)		
36.	Does turning your head bring on or make your dizziness worse? Which direction? _____	Yes	No
37.	Does lying down or sitting up bring on your dizziness?	Yes	No
38.	Does standing up bring on your dizziness?	Yes	No
39.	Do you find it especially difficult to walk in the dark?	Yes	No
40.	Is there any relationship between your dizziness and tension or anxiety in your life? Explain: _____	Yes	No
41.	Do you know of anything that will precipitate an attack? What? _____	Yes	No
42.	Do you know of anything that will stop or make your dizziness better? What? _____	Yes	No
43.	Does sleep make it better?	Yes	No

PRESENT / PAST MEDICAL HISTORY

44.	Have you ever had a concussion, skull fracture, or been knocked unconscious? (Circle all that apply)	Yes	No
45.	Have you ever had a whiplash or do you have a neck disease?	Yes	No
46.	Do you have an eye disorder?	Yes	No
47.	Do you wear glasses?	Yes	No
48.	Have you ever had ear infections or other ear diseases? Describe:_____	Yes	No
49.	Had you been taking prescription or nonprescription medications regularly before your dizziness started? If so, list them. _____	Yes	No
50.	Have you in the past or do you now smoke? Packs per day_____ Years_____	Yes	No
51.	Have you in the past or are you now a heavy alcohol drinker? How many drinks per day? _____ Years _____	Yes	No
52.	Have you in the past or do you now have: (circle all that apply) 1) Diabetes 2) Seizures 3) Migraines 4) High / Low blood pressure 5) Cancer 6) Stroke 7) Heart attack 5) Peripheral Vascular Disease		
53.	Do you know of any possible cause of your dizziness? What? _____	Yes	No
54.	Has another doctor done tests to evaluate your dizziness? Dr._____ Phone_____ Date_____ Diagnostic tests done: (circle all that apply) MRI CT Other: _____ Location of test results: _____	Yes	No

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