



## Dizziness Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**CHIEF CONCERN: Please check all the symptoms that you are currently experiencing:**

- Dizziness                       Lightheadedness                       Vertigo (spinning)  
 Imbalance                       Unsteadiness                       Falling

Describe in your own words how your dizziness or imbalance problem feels: \_\_\_\_\_

**HISTORY OF PRESENT ILLNESS**

1. When did your problem start (date): \_\_\_\_\_ Was there any related event?     YES     NO
  - a. If YES, check all that apply:
    - An ear infection                       A cold
    - Auto accident                       Other: \_\_\_\_\_
2. Was the onset of your problem:     Gradual     Sudden     Overnight     Other: \_\_\_\_\_
3. Is your dizziness/imbalance:     Constant     It comes and goes in spells or attacks
  - a. If it comes and goes in spells or attacks:
    - They occur every #    \_\_\_ hours    \_\_\_ days    \_\_\_ weeks    \_\_\_ months
    - And they last #    \_\_\_ seconds    \_\_\_ minutes    \_\_\_ hours    \_\_\_ days    \_\_\_ months
    - Do you have any warning the attacks will occur?                       YES     NO
    - If YES, describe: \_\_\_\_\_
    - Are you completely free of dizziness/imbalance between attacks?     YES     NO
4. Does your dizziness/imbalance occur with position changes?                       YES     NO
  - a. If YES, check all that apply:
    - Rolling your body right or left                       Turning your head left or right
    - Looking up, or head back position                       Bending over, or head down position
    - Going from lying to sitting position                       Other: \_\_\_\_\_
5. Do you know of anything that makes your dizziness/imbalance better?                       YES     NO
  - a. If YES, check all that apply:
    - Not moving your head                       Rest
    - Medication: \_\_\_\_\_
    - Other: \_\_\_\_\_
6. Do you know of anything that makes your dizziness/imbalance worse?                       YES     NO
  - a. If YES, check all that apply:
    - Moving your head                       Riding or driving in the car
    - Large crowds or busy walkways                       When your hungry or haven't eaten
    - Other: \_\_\_\_\_
7. Is your dizziness/imbalance currently:     Getting better     Same     Getting worse     Variable
  - a. If variable, rate the severity of your symptoms at the best times and the worst times on a scale of 1-10 with 10 being the worst.    \_\_\_\_\_ Best times                      \_\_\_\_\_ Worst times
8. Do your symptoms limit your daily activities?                       YES     NO

9. Do you have trouble walking in the dark or at dusk?  YES  NO
10. Do you have trouble walking on uneven surfaces (eg. lawn)?  YES  NO
11. When dizzy/imbalanced, must you support yourself to stand or walk?  YES  NO  
 a. If YES, how do you support yourself? \_\_\_\_\_
12. Have you ever fallen due to your dizziness/imbalance?  YES  NO  
 a. If YES, # of falls: \_\_\_\_\_ # of near falls: \_\_\_\_\_  
 b. Do you tend to fall to the:  Right  Left  Back  Front  All
13. Do you have a history of migraine headaches?  YES  NO
14. Did you recently get new glasses or has there been a change in your vision?  YES  NO
15. Have you ever had IV antibiotics or chemotherapy?  YES  NO

**DO YOU HAVE ANY OF THE FOLLOWING EAR RELATED SYMPTOMS**

16. Do you have difficulty hearing?  YES  NO  
 a. If YES, when did it start: \_\_\_\_\_  Both ears  Right ear  Left ear
17. Do you wear hearing aids?  YES  NO
18. Do you experience noise or ringing in your ears?  YES  NO  
 a. If YES, which ears:  Both ears  Right ear  Left ear  
 b. Describe the noise:  Ringing  Buzzing  Chirping  Hissing  Other  
 c. Is it:  Steady  Pulsatile  Constant  Occasional  
 d. Does anything stop the noise or make it better: \_\_\_\_\_
19. Do you have pain, fullness, or pressure in your ears?  YES  NO  
 a. If YES, which ears:  Both ears  Right ear  Left ear  
 b. Does it coincide with your dizziness/imbalance?  YES  NO

**HAVE YOU EXPERIENCED ANY OF THE FOLLOWING (Indicate if constant or episodic):**

Yes	No		Constant	Episodic	Comments
<input type="checkbox"/>	<input type="checkbox"/>	1. Double/blurred vision or blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	2. Numbness of face or extremities	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	3. Weakness in arms or legs	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	4. Clumsiness in arms or legs	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	5. Confusion or loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	6. Difficulty with speech or swallowing	<input type="checkbox"/>	<input type="checkbox"/>	_____

**PLEASE NOTE ANY PRIOR RELEVANT EVALUATIONS, TESTS, TREATMENTS**

20. Have you seen other healthcare providers for this problem?  YES  NO  
 a. If YES, who:  Primary MD  Ear, Nose, Throat MD (ENT)  Neurologist  
 Cardiologist  Emergency Room MD  Physical Therapist
21. Have you had tests done for this problem elsewhere?  YES  NO  
 ENG/VNG Where: \_\_\_\_\_ When: \_\_\_\_\_ Results: \_\_\_\_\_  
 MRI/CT Where: \_\_\_\_\_ When: \_\_\_\_\_ Results: \_\_\_\_\_  
 Hearing tests Where: \_\_\_\_\_ When: \_\_\_\_\_ Results: \_\_\_\_\_  
 Other: \_\_\_\_\_