

DIZZINESS QUESTIONNAIRE
DR. STEPHEN SEGEBRECHT

NAME _____ DATE _____

I. What are the general characteristics of your dizziness? Please read the entire list first, then put an X in the first box for YES or the second box for NO and fill in the Blank Spaces.

YES NO

- 1.) When did dizziness first occur? _____
- 2.) When my dizziness first started it began quickly.
- 3.) When my dizziness first started it began slowly.
- 4.) _____
How long did the first spell last? _____
- 5.) My dizziness is: (Circle all that apply) Constant In Attacks
- 6.) _____
If in attacks: How often _____
How long do they last? _____
- Do you have any warning that the attack is about to start?
- 7.) Are you completely free of dizziness between attacks?
- 8.) Does dizziness occur only in certain positions?
- 9.) Do you have trouble walking in the dark?
- 10.) When dizzy, must you support yourself when standing?
- 11.) Do you know any possible cause of your dizziness?
If YES, what? _____
- 12.) Do you know anything that will:
- Stop your dizziness or make it better.
- Make your dizziness worse?
- Cause an attack?
- 13.) Were you exposed to any irritating fumes, paints, etc., at the onset of the dizziness?

II. When you are "dizzy" do you experience any of the following sensations? Please read the entire list first, then put an X in the first box for YES or the second box for NO and fill in the Blank Spaces.

YES NO

- 1.) Lightheadedness
- 2.) Swimming sensation in the head
- 3.) Blacking out
- 4.) Loss of consciousness
- 5.) Tendency to fall (Circle all that apply)
To the Right To the Left Forward Backward

- 6.) Objects are spinning or turning around you
- 7.) Sensation that you are spinning or turning inside with outside objects remaining stationary
- 8.) Loss of balance when walking (Circle all that apply)
veering to the right veering to the left
- 9.) Headache
- 10.) Nausea or vomiting
- 11.) Pressure in the head
- 12.) Lightning-like flashes in your eyes

III. Do you have any of the following symptoms? Put an "X" in the appropriate box and circle which ear it involves.

- | | YES | NO | | | | |
|-----|--------------------------|--------------------------|---|-----------|-----------|----------|
| 1.) | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty hearing (Circle all that apply) | Both ears | Right Ear | Left Ear |
| | | | When did this start _____ | | | |
| | <input type="checkbox"/> | <input type="checkbox"/> | Is it getting worse? | | | |
| 2.) | <input type="checkbox"/> | <input type="checkbox"/> | Does your hearing change with your dizziness | | | |
| | | | If YES, how? _____ | | | |
| 3.) | <input type="checkbox"/> | <input type="checkbox"/> | Noise in your ears? (Circle all that apply) | Both ears | Right Ear | Left Ear |
| | | | How long _____ Left ear _____ Right Ear _____ | | | |
| | | | Describe the noise _____ | | | |
| | <input type="checkbox"/> | <input type="checkbox"/> | Does the noise change with the dizziness? | | | |
| | | | If YES, how? _____ | | | |
| | <input type="checkbox"/> | <input type="checkbox"/> | Does anything stop the noise or make it worse? | | | |
| | | | If YES, what? _____ | | | |
| 4.) | <input type="checkbox"/> | <input type="checkbox"/> | Fullness/stuffiness in your ears | Both ears | Right Ear | Left Ear |
| | <input type="checkbox"/> | <input type="checkbox"/> | Does this change when you are dizzy | | | |
| 5.) | <input type="checkbox"/> | <input type="checkbox"/> | Pain in your ears | Both ears | Right Ear | Left Ear |
| 6.) | <input type="checkbox"/> | <input type="checkbox"/> | Discharge from you ears | Both ears | Right Ear | Left Ear |
| 7.) | <input type="checkbox"/> | <input type="checkbox"/> | Do you get headaches associated with your dizziness | | | |
| | | | If YES, where do you feel the pain? _____ | | | |
| | | | How long does the pain last? _____ | | | |
| | | | What relieves your headaches? _____ | | | |

IV. Have you ever experienced any of the following symptoms? Put an "X" in the appropriate box and circle if CONSTANT or in EPISODES.

	YES	NO			
1.)	<input type="checkbox"/>	<input type="checkbox"/>	Double vision	Constant	Episodes
2.)	<input type="checkbox"/>	<input type="checkbox"/>	Numbness of face or extremities	Constant	Episodes
3.)	<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision or blindness	Constant	Episodes
4.)	<input type="checkbox"/>	<input type="checkbox"/>	Weakness in arms or legs	Constant	Episodes
5.)	<input type="checkbox"/>	<input type="checkbox"/>	Clumsiness in arms or legs	Constant	Episodes
6.)	<input type="checkbox"/>	<input type="checkbox"/>	Confusion or loss of consciousness	Constant	Episodes
7.)	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty with speech	Constant	Episodes
8.)	<input type="checkbox"/>	<input type="checkbox"/>	Tingling around mouth	Constant	Episodes
9.)	<input type="checkbox"/>	<input type="checkbox"/>	Spots before the eyes	Constant	Episodes
10.)	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	Constant	Episodes

If YES, where do you feel the pain? _____

How long does the pain last? _____

What time of day do you get headaches? _____

What relieves your headaches? _____

V. Please answer the following questions.

How many ounces of caffeinated drinks (coffee, tea or pop) do you drink daily? _____

How much salt do you use? (circle one)

Add a lot Add a little None added Avoid all salty foods

VI. Please check the appropriate box for either YES or NO.

	YES	NO	
1.)	<input type="checkbox"/>	<input type="checkbox"/>	Do you get dizzy after exertion or overwork
2.)	<input type="checkbox"/>	<input type="checkbox"/>	Have you had any recent unusual straining/heavy lifting
3.)	<input type="checkbox"/>	<input type="checkbox"/>	Did you get new glasses recently
4.)	<input type="checkbox"/>	<input type="checkbox"/>	Do you tend to get upset easily
5.)	<input type="checkbox"/>	<input type="checkbox"/>	Do you get dizzy when you have not eaten for a long time
6.)	<input type="checkbox"/>	<input type="checkbox"/>	Is your dizziness connected with your menstrual period
7.)	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a neck injury
8.)	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever been knocked out badly enough to have to go to the hospital