

Dizziness Questionnaire
Dr. Robert Dinsdale

NAME _____ DATE _____

I. General characteristics of your dizziness (please circle)

- | | |
|--|----------|
| 1. Do you have any warning that the attack is about to start? | Yes / No |
| 2. Are you completely free of dizziness between attacks? | Yes / No |
| 3. Do you have trouble walking in the dark? | Yes /No |
| 4. When you are dizzy, do you have to support yourself when standing? | Yes/ No |
| 5. Do you know any possible cause of your dizziness? | Yes/No |
| If yes, what is the cause? _____ | |
| 6. Do you know anything that will stop your dizziness or make it better? | Yes/No |
| If yes, what? _____ | |
| 7. Do you know anything that will start your dizziness or make it worse? | Yes/No |
| If yes, what? _____ | |
| 8. Is your dizziness worse when you turn over in bed? | Yes / No |
| 9. Do you get dizzy after exertion or overwork? | Yes / No |
| 10. Do you get dizzy when you have not eaten on your regular schedule? | Yes / No |

II. Other sensations that occur with your dizziness

- | | |
|--|----------|
| 1. Lightheadedness | Yes / No |
| 2. Swimming sensation in the head | Yes / No |
| 3. Blacking out | Yes / No |
| 4. Loss of consciousness | Yes / No |
| 5. Tendency to fall | Yes / No |
| To the right? | Yes / No |
| To the left? | Yes/ No |
| Forward? | Yes / No |
| Backward? | Yes / No |
| 6. A feeling that objects are spinning or turning around you | Yes / No |
| 7. A feeling that you are spinning or turning but objects around you are staying still | Yes / No |
| 8. Loss of balance when walking | Yes/ No |
| 9. Headache | Yes / No |
| 10. Nausea or vomiting | Yes/No |
| 11. Sensitivity to light | Yes / No |
| 12. Sensitivity to noise | Yes/ No |
| 13. Pressure or fullness in your ear(s) | Yes/ No |
| 14. Change in your hearing | Yes / No |
| 15. Change in ringing in the ears | Yes / No |
| 16. Flashes in your eyes like lightning | Yes/ No |

(Continued on back page)

III. Do you have any of these other ear troubles? Please circle yes or no as well as which ear is involved.

- | | |
|-------------------------------------|---------------------|
| 1. Difficulty hearing | Yes/No |
| Which ear? | Both / Right / Left |
| When did this begin? _____ | |
| Is it getting worse? | Yes / No |
| 2. Noise in your ears | Yes/ No |
| Which ear? | Both / Right / Left |
| Does it change with your heartbeat? | Yes/ No |
| 3. Pain in your ears | Yes/ No |
| Which ear? | Both / Right /Left |
| 4. Drainage from your ears | Yes /No |
| Which ear? | Both / Right/ Left |

IV. Please answer these final questions about situations that sometimes go along with dizziness

- | | |
|---|----------------------------|
| 1. Double vision | Yes / No |
| 2. Numbness of face or arms or legs | Yes/ No |
| 3. Blurred vision or blindness | Yes/ No |
| 4. Weakness or clumsiness of your arms or legs | Yes / No |
| 5. Confusion | Yes/ No |
| 6. Difficulty with speech | Yes/ No |
| 7. Difficulty with swallowing | Yes/ No |
| 8. Tingling around mouth | Yes/ No |
| 9. Spots in front of your eyes | Yes / No |
| 10. Have you ever been knocked out badly enough to have to go to the hospital? | Yes / No |
| 12. Have you ever had a neck injury? | Yes / No |
| 13. Headaches | Yes / No |
| How long do your headaches last? | Less than an hour |
| | 1-6 hours |
| | _____Hours |
| | _____Days |
| | Constant |
| What relieves your headaches? | Aspirin or Tylenol |
| | Prescription pain medicine |
| | Sleep |
| 14. Have you had any recent unusually heavy lifting or straining? | Yes /No |
| 15. Did you get new glasses recently? | Yes / No |
| 16. Do you tend to get upset easily? | Yes/ No |
| 17. How many ounces of caffeinated drinks (coffee, tea, pop) do you drink each day? | Zero / _____ounces |
| 18. How much salt do you use? Add a lot / Add a little / None added / Avoid | |