Adult & Pediatric Ear, Nose & Throat
Dizziness Questionnaire

Name _____ **Date** _____

When you are dizzy, do you experience any of the following sensations? Please read the entire list first.

Yes No Lightheadedness or swimming sensation in the head
Yes No Blackening out or loss of consciousness
Yes No Tendency to fall: To the right
Yes No To the left
Yes No Forward
Yes No Backward
Yes No Objects spinning or turning around you
Yes No Sensation that you are turning or spinning inside, with objects remaining stationary
Yes No Loss of balance when walking: Veering to right
Yes No Veering to left
Yes No Headache
Yes No Nausea or vomiting
Yes No Pressure in the head

My dizziness is:

Yes No Constant
Yes No In attacks

When did the dizziness first occur? _____
If in attacks:
How often? _____
How long do they last? _____
When was the last attack? _____
Yes No Do you have any warning that the attack is about to start?
Yes No Do they occur at any particular time of the day or night?
Yes No Are you completely free of dizziness between attacks?
Yes No Does change of position make you dizzy?
Yes No Do you have trouble walking in the dark?
Yes No When you are dizzy, must you support yourself when standing?
Yes No Do you know of any possible causes of your dizziness?
_____

Do you know of anything that will:

Yes No Stop your dizziness or make it better
Yes No Make your dizziness better
Yes No Make your dizziness worse
Yes No Precipitate an attack . . .
(Fatigue, Hunger, Menstrual Period, Stress, Emotional Upset)
Yes No Were you exposed to any irritating fumes, paints, etc. at the onset of dizziness?
Yes No **If you are allergic** to any medications please list them **all** on the attached medication list.
Yes No If you ever injured your head, were you unconscious?
Yes No **If you take any medications** regularly, for any reason, please list them all on the attached medication list. (Including supplements, herbs or vitamins)
Yes No Do you use tobacco in any form? If so, how much? _____

Do you have any of the following symptoms? Please circle yes or no and ear involved.

Yes No Difficulty hearing? Both Ears Yes No
Yes No Noise in your ears? Both Ears Yes No
Describe the noise: _____
Yes No Does noise change with dizziness? If so, how?
_____
Yes No Fullness or stuffiness in your ears? Both Ears Yes No
Yes No Pain in your ears? Both Ears Yes No
Yes No Discharge from your ears? Both Ears Yes No

Have you experienced any of the following?

Yes No Double vision, blurred vision or blindness: Constant In Episodes
Yes No Numbness of arms or legs Constant In Episodes
Yes No Numbness of face Constant In Episodes
Yes No Weakness of arms or legs Constant In Episodes
Yes No Clumsiness of arms or legs Constant In Episodes
Yes No Confusion or loss of consciousness Constant In Episodes
Yes No Difficulty with speech Constant In Episodes
Yes No Difficulty with swallowing Constant In Episodes
Yes No Pain in the neck or shoulder Constant In Episodes