Lawrence Otolaryngology Associates
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