Lawrence Otolaryngology Associates
DIZZINESS QUESTIONNAIRE
DR. STEPHEN SEGEBRECHT

NAME ____ **DATE**______________________

I. What are the general characteristics of your dizziness? Please read the entire list first, then circle Yes or No and fill in the Blank Spaces.

1.) □ □ When did dizziness first occur? ______________________________

2.) **YES** **NO** When my dizziness first started it began quickly.

3.) **YES** **NO** □ 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.) **YES** **NO** If in attacks: How often ____________________________________

How long do they last? __________________________

YES **NO** □ Do you have any warning that the attack is about to start?

7.) **YES** **NO** □ Are you completely free of dizziness between attacks?

8.) **YES** **NO** □ Does dizziness occur only in certain positions?

9.) **YES** **NO** Do you have trouble walking in the dark?

10.) **YES** **NO** When dizzy, must you support yourself when standing?

11.) **YES** **NO** Do you know any possible cause of your dizziness?

If YES, what? ______________________________________

12.) Do you know anything that will:

YES **NO** □ Stop your dizziness or make it better.

YES **NO** Make your dizziness worse?

YES **NO** Cause an attack?

13.) **YES** **NO** □ 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 circle Yes or No and fill in the Blank Spaces.

1.) **YES** **NO** Lightheadedness

2.) **YES** **NO** □ Swimming sensation in the head

3.) **YES** **NO** Blacking out

4.) **YES** **NO** Loss of consciousness

5.) **YES** **NO** Tendency to fall (Circle all that apply)

To the Right To the Left Forward Backward

6.) **YES** **NO** Objects are spinning or turning around you

7.) **YES** **NO** Sensation that you are spinning or turning inside with outside objects remaining stationary

8.) **YES** **NO** Loss of balance when walking (Circle all that apply)

veering to the right veering to the left

9.) **YES** **NO** Headache

10.) **YES** **NO** Nausea or vomiting

11.) **YES** **NO** Pressure in the head

12.) **YES** **NO** Lightning-like flashes in your eyes

III. Do you have any of the following symptoms? Circle Yes or NO and then circle which ear it involves.

1.) **YES** **NO** Difficulty hearing (Circle all that apply) Both ears Right Ear Left Ear

When did this start____

Is it getting worse?

2.) **YES** **NO** Does your hearing change with your dizziness

If YES, how? ____

3.) **YES** **NO** Noise in your ears? (Circle all that apply) Both ears Right Ear Left Ear

How long__________ Left ear___________ Right Ear ___________

Describe the noise ____

Does the noise change with the dizziness?

If YES, how? ____

Does anything stop the noise or make it worse?

If YES, what? ____

4.) **YES** **NO** Fullness/stuffiness in your ears Both ears Right Ear Left Ear

Does this change when you are dizzy

5.) **YES** **NO** Pain in your ears Both ears Right Ear Left Ear

6.) **YES** **NO** Discharge from you ears Both ears Right Ear Left Ear

7.) **YES** **NO** 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? Circle Yes or No and then circle if CONSTANT or in EPISODES.

1.)	**YES**	**NO**	Double vision	Constant	Episodes
2.)	**YES**	**NO**	Numbness of face or extremities	Constant	Episodes
3.)	**YES**	**NO**	Blurred vision or blindness	Constant	Episodes
4.)	**YES**	**NO**	Weakness in arms or legs	Constant	Episodes
5.)	**YES**	**NO**	Clumsiness in arms or legs	Constant	Episodes
6.)	**YES**	**NO**	Confusion or loss of consciousness	Constant	Episodes
7.)	**YES**	**NO**	Difficulty with speech	Constant	Episodes
8.)	**YES**	**NO**	tingling around mouth	Constant	Episodes
9.)	**YES**	**NO**	Spots before the eyes	Constant	Episodes
10)	**YES**	**NO**	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 Circle either YES or NO.

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