



## DIZZINESS QUESTIONNAIRE

Name: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date: \_\_\_\_\_

The following questions refer to your feeling of dizziness. Please answer them by circling “yes” or “no” and fill in all blanks.

Please describe the sensation you feel in your own words without using the word “dizzy.”

\_\_\_\_\_

\_\_\_\_\_

### Medicines

Please list all medicines you are currently taking (including pain medicines, nonprescription medicines, nerve pills, sleeping pills, and birth control).

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What **studies** have been done previously regarding your dizziness? i.e., hearing test, CT scan brain, MRI scan brain or balance testing (ENG)?

\_\_\_\_\_

\_\_\_\_\_

<b>Do you ever have any of the following sensations</b>	<b>Yes</b>	<b>No</b>
Spinning in circles?	<input type="checkbox"/>	<input type="checkbox"/>
Falling to one side?	<input type="checkbox"/>	<input type="checkbox"/>
World spinning around you?	<input type="checkbox"/>	<input type="checkbox"/>
<b>The following questions refer to a typical dizzy spell:</b>		
Do the dizzy spells come in attacks?	<input type="checkbox"/>	<input type="checkbox"/>
How often?		
How long?		
Date of first spell?		
Are you free from dizziness between attacks?	<input type="checkbox"/>	<input type="checkbox"/>
Does your hearing change with an attack?	<input type="checkbox"/>	<input type="checkbox"/>
Are you dizzier in certain positions?	<input type="checkbox"/>	<input type="checkbox"/>
Which position?		
Are you nauseated during an attack?	<input type="checkbox"/>	<input type="checkbox"/>
Had a recent cold or flu preceding recent dizzy spells?	<input type="checkbox"/>	<input type="checkbox"/>
Fullness or pressure or ringing in your ears?	<input type="checkbox"/>	<input type="checkbox"/>
Recent onset of pain or discharge in your ear?	<input type="checkbox"/>	<input type="checkbox"/>
Trouble walking in the dark?	<input type="checkbox"/>	<input type="checkbox"/>
Are you better if you sit or lie perfectly still?	<input type="checkbox"/>	<input type="checkbox"/>



<b>Miscellaneous:</b>	<b>Yes</b>	<b>No</b>
Are you allergic to any medicines?	<input type="checkbox"/>	<input type="checkbox"/>
What?		
Are you allergic to anything?	<input type="checkbox"/>	<input type="checkbox"/>
What?		
Have you ever had weakness or faintness a few hours after eating?	<input type="checkbox"/>	<input type="checkbox"/>
Are you dizzy mainly when you sit or stand up quickly?	<input type="checkbox"/>	<input type="checkbox"/>

**I have reviewed the above information with the patient.**

\_\_\_\_\_

Date: \_\_\_\_\_