



Dizziness Questionnaire

Completion of this questionnaire will aid in your diagnosis and treatment. Please ask your doctor if you have trouble answering any questions. Please read the questions first and then circle the answers.

Name _____ Age _____ Date _____

Male Female Dominant Hand Right Left

Address _____ Telephone No. _____

What has been your main occupation in life? _____

SYMPTOM CHECKLIST Circle your **One Main Symptom** and any secondary symptoms

Main (mark only one)

Secondary (mark as many as apply)

- | | |
|---|--------------------------|
| <input type="checkbox"/> A) Dizzy with a clear sensation of spinning | <input type="checkbox"/> |
| <input type="checkbox"/> B) Dizzy with non-spinning sensation of movement | <input type="checkbox"/> |
| <input type="checkbox"/> C) Dizzy without sensation of movement | <input type="checkbox"/> |
| <input type="checkbox"/> D) A feeling of lightheadedness | <input type="checkbox"/> |
| <input type="checkbox"/> E) Tendency to lose balance or fall | <input type="checkbox"/> |
| <input type="checkbox"/> F) Feeling about to faint | <input type="checkbox"/> |
| <input type="checkbox"/> G) Nausea or vomiting | <input type="checkbox"/> |
| <input type="checkbox"/> H) Tingling of hands or feet | <input type="checkbox"/> |
| <input type="checkbox"/> I) Shortness of breath | <input type="checkbox"/> |
| <input type="checkbox"/> J) Disorientation or confusion | <input type="checkbox"/> |
| <input type="checkbox"/> K) Pain behind eyes on urination | <input type="checkbox"/> |
| <input type="checkbox"/> L) Difficulty walking | <input type="checkbox"/> |
| <input type="checkbox"/> M) Neck stiffness or pain | <input type="checkbox"/> |
| <input type="checkbox"/> N) Hearing loss | <input type="checkbox"/> |
| <input type="checkbox"/> O) Headache | <input type="checkbox"/> |
| <input type="checkbox"/> P) Memory Loss | <input type="checkbox"/> |

Other symptoms

When did your symptoms begin? _____

Did your symptoms come on suddenly? Yes No

Did your symptoms come in attacks? Yes No

If your symptoms come in attacks, how long does a typical attack last? _____

When was your last attack? _____

How often do they occur? _____

Do they occur at any particular time of day? Yes No

If yes, when _____

Are there other symptoms associated with attacks? Yes No

If so what are they? _____

Are you completely symptom free between attacks? Yes No

If your symptoms are constant, is there a time of day when most affected? _____

Least affected? _____

Were you suffering from another disease or infection at the time your symptoms came on? Yes No

If yes, what? _____

Do your symptoms occur only in certain body or head positions? Yes No

If yes, what are they? _____

Do your symptoms occur only when changing positions such as turning in bed? Yes No

If yes, which change most reliably brings it on? _____

Do you know of anything that will make your symptoms better? _____

or worse? _____

or brings on an attack? _____

Does coughing, sneezing or blowing your nose usually bring on your symptoms? Yes No

Does a change in altitude usually bring on your symptoms? Yes No

Have you ever seriously injured your head or neck? Yes No

If so, when? _____

Was this related to your symptoms? Yes No

If so, how? _____

Do you smoke or chew tobacco? Yes No

If yes, how much? _____

Do you drink alcoholic beverages? Yes No

If so, how much on average? _____

Do you have a history of susceptibility to motion sickness? Yes No

Do you experience migraine (sick) headaches? Yes No

Do you have a family history of migraine headaches? Yes No

If so, in whom? _____

Please list any major medical problems and their dates of onset _____

Please list all medications you are currently taking and circle any you feel may be causing your symptoms _____

Please list any treatment you have been given for your symptoms and circle any that have helped _____

Has anyone in your family ever had a problem with imbalance or dizziness? Yes No

If so, who and when? _____

Do you have a family history of any neurological diseases? Yes No

If so, what? _____

Do you know of any possible cause of your symptoms? Yes No

What? _____

PLEASE CHECK THE APPROPRIATE LINE IF YOU HAVE ANY OF THE FOLLOWING

	Right Ear	Left Ear	Both Ears
Difficulty in hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing distortion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Noises in ear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear fullness or pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain in ear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Discharge from ear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	With Symptoms	Without Symptoms
Doubled vision	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>
Oscillating (wiggling) vision	<input type="checkbox"/>	<input type="checkbox"/>
Tingling around mouth or face	<input type="checkbox"/>	<input type="checkbox"/>
Numbness of feet or hand	<input type="checkbox"/>	<input type="checkbox"/>
Weakness of arms or legs	<input type="checkbox"/>	<input type="checkbox"/>
Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Pain in neck or shoulder	<input type="checkbox"/>	<input type="checkbox"/>
Clumsiness of arms or legs	<input type="checkbox"/>	<input type="checkbox"/>
Confusion	<input type="checkbox"/>	<input type="checkbox"/>
Loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with speech	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Convulsion or seizures	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations or chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>

Please estimate your current level of life stress on a scale of 1-10 (10 being the greatest) _____

Do you exercise regularly? Yes No

If yes, what type? _____

Were you in the military service? Yes No

Branch _____ Years _____ Artillery or noise exposure? _____

Have you ever been given ototoxic antibiotics? Yes No

Please check Neomycin Streptomycin Kanamycin Gentamicin

Do you have any other noise exposures? Yes No

Where and what? _____

Any other comments concerning your symptoms or health? _____
