Name _____ Date_____

DIZZINESS QUESTIONNAIRE

1) Do you have a feeling of spinning when dizzy? Yes No
2) Are you falling from side to side when dizzy? Yes No
3) Does your dizziness come in attacks? Yes No
   If so, how long do the attacks last? _____
4) Do certain positions make your dizziness worse? Yes No
   If so, which positions? _____
5) How long has this dizziness bothered you? _____
6) Would you describe the dizziness as "light-headed?" Yes No
7) Have you recently changed any medications? Yes No
   If so, what medication changes have been made? _____
   _____
8) Does anyone in your immediate family have dizziness? Yes No
9) Do you become nauseated with your dizziness? Yes No
10) Do your ears suddenly ring when you become dizzy? Yes No
    If so, which ear? RIGHT LEFT BOTH
11) Does either ear frequently feel full or plugged?
    If so, which ear? RIGHT LEFT BOTH
12) Have you ever "blacked out" when dizzy? Yes No
13) Have you ever had numbness in the face? Yes No
14) Have you ever had numbness in the feet and hands? Yes No
15) History of hip surgery? Yes No If yes, which hip? _____
16) History of knee surgery? Yes No If yes, which knee? _____
17) Speech problems that occur with dizziness? Yes No
18) Any blurry or double vision with the dizziness? Yes No
19) History of ear surgeries? Yes No
    If so, which type of ear surgery? _____
20) Significant history of headaches or migraines? Yes No
21) Are you taking medications for dizziness/associated symptoms?
    If so, what medications? _____

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