CUMBERLAND VALLEY ENT CONSULTANTS

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DIZZY QUESTIONNAIRE

Name: _____ Date: _____

I)When you are "dizzy" do you experience any of the following sensations?
(Please read the entire list first, then check yes or no **to describe your feelings most accurately.**)

Yes	No	
b	b	1. Light-headedness or swimming sensation in the head?
b	b	2. Blacking out or loss of consciousness?
b	b	3. Tendency to fall: To the right ?
b	b	To the left?
b	b	Forward?
b	b	Backward?
b	b	4. Objects spinning or swimming around you?
b	b	5. Sensation that you are turning or spinning inside with outside objects remaining stationary?
b	b	6. Sensation of the environment moving up and down while you walk?
b	b	7. Loss of balance when walking: Veering to the right?
b	b	Veering to the left?
b	b	8. Headache?
b	b	9. Nausea/vomiting?
b	b	10. Pressure in the head?
b	b	11. Palpitations, perspiration, shortness of breath, or a feeling of panic?

II) Please check yes or no and fill in the blanks. Please answer all questions.

Yes	No

b b 1. My dizziness is: Constant.

b b In attacks.

2. When did dizziness first occur? _____

3. If in attacks: How often? _____

How long do they last? _____

When was last attack? _____

b b Do you have any warning that the attack is about to start?

b b Do they occur at any particular time of day or night?

b b Are you completely free of dizziness between attacks?

Yes **No**

b b 4. Does change of position make you dizzy?

b b 5. Do you have trouble walking in the dark?

b b 6. When you are dizzy, must you support yourself when standing?

b b 7. List the possible causes of dizziness? _____

8. Do you know of anything that will:

b b Stop your dizziness or make it better? _____

b b Make your dizziness worse? _____

b b Precipitate an attack? (eg: Fatigue, exertion, hunger, stress, emotional upset or menstrual period)

_____

b b 9. Were you exposed to any irritating fumes, paints, etc. at the onset of dizziness?

b b 10. Please list any medications you are allergic to _____

_____

b b 11. If you ever injured your head, were you unconscious?

12. Please list any medications you take regularly _____

_____

b b 13. Do you use tobacco in any form (please list) _____

How much? _____

III) Do you have any of the following symptoms? please check yes or no and which ear is involved.

Yes	**No**		**Right**	**Left**	**Both**
b	b	1. Difficulty hearing?	b	b	b
b	b	2. Noise in your ears?	b	b	b

Describe the noise _____

Does the noise change with dizziness? If so, how? _____

b	b	3. Fullness or stuffiness?	b	b	b
b	b	4. Pain in your ears?	b	b	b
b	b	5. Discharge from your ears	b	b	b

IV) Have you experienced any of the following symptoms? Please check yes or no and if constant or in episodes.

Yes	**No**		**Constant**	**In Episodes**
b	b	1. Double vision, blurred vision or blindness.	b	b
b	b	2. Numbness of face.	b	b
b	b	3. Numbness of arms or legs.	b	b
b	b	4. Weakness of arms or legs.	b	b
b	b	5. Clumsiness of arms or legs.	b	b
b	b	6. Confusion or loss of consciousness.	b	b
b	b	7. Difficulty with speech.	b	b
b	b	8. Difficulty with swallowing.	b	b
b	b	9. Pain in the neck or shoulder.	b	b
b	b	10. Seasickness or car sickness.	b	b

Thank You