Dizziness History Questionnaire

Name:_____ Age:_____ Todays' date:_____

When was the *first* time ever in your life you had dizziness?
_____

What were the circumstances?
_____
_____

When was the *last* time you experienced dizziness?
_____

What were the circumstances?
_____
_____

Currently, my dizziness…
___ is constant.
___ is always there, but changes in intensity.
___ comes and goes.

If comes and goes:
How long does it typically last? ___ seconds/minutes/hours (Circle one)
How often does it typically occur? ___ times per: hour/day/week/month/year

My dizziness mostly consists of…(Check all that apply)
___ spells of spinning with nausea.
___ off-balance sensation without dizziness.
___ a light-headed or near faint sensation.
__) other. Please explain:_____

Between episodes I feel…(Check one)
___ dizzy or off balance.
___ mostly normal.
___ other. Please explain:_____

My episodes occur…(Check all that apply)
___ spontaneously. Nothing I do seems to bring them on or turn them off.
___ only when standing or walking.
___ in relation to any head movements.
___ in relation to only specific head positions. Please describe:_____
___ in relation to very specific body positions. Please describe:_____

When I roll over in bed…(Check one)

___ nothing unusual happens.
___ the room seems to spin sometimes.
___ the room spins every time.

Is there anything that you can do to make you dizziness go away? (sit, lay down, close eyes…) Please explain:

_____

_____

Circle all that apply:

I have hearing difficulty …….…….Right …..Left…..Both
I have ringing or other sounds …….……Right …..Left.….Both
I have fullness ……...…..Right ..…Left…..Both
I have had ear surgery …….….Right ..…Left…..Both

Circle Yes or No

Did you have cold, flu, or virus symptoms shortly before the onset of dizziness? Yes/No
Did you cough, sneeze, fly in a plane, swim under water, do any heavy lifting, or have a head trauma shortly before the onset of your dizziness? Yes/No
If you had head trauma prior to dizziness, did you lose consciousness? Yes/No
Were you exposed to any irritating fumes, paints, etc. at the onset of dizziness? Yes/No
Do you get dizzy when you have not eaten for a long time? Yes/No
Is your dizziness connected with your menstrual period? Yes/No
Did you get new glasses recently? Yes/No
I consider myself to be an anxious or tense type of person. Yes/No
I am under a great deal of stress. Yes/No

In the past year I have had…(Check all that apply)

___ loss of consciousness
___ seizures or convulsions
___ slurring of speech
___ difficulty swallowing
___ tingling around mouth
___ double vision
___ spots before the eyes
___ occasional loss of vision
___ severe headache or migraine
___ palpitations of the heartbeat
___ weakness in one hand, arm or leg
___ tendency to fall
___ loss of balance when walking

I have or have had…(Check all that apply)

___ Diabetes
___ High blood pressure
___ Arthritis
___ Irregular heartbeat
___ Stroke
___ Migraine headaches
___ Neck and/or back injury
___ Allergies

Please check below for any medications you have tried for dizziness or are currently taking:

Medication	Taken in past	Taking now	Helps
Antivert (Meclizine)			
Valium (Diazepam)			
Dyazide “water pills”			
Other:_____			

Have you ever been previously evaluated for dizziness?

_____

_____