MD Neurology
Dizziness History Questionnaire

Name:_____ **DOB:**_____ **Date:** _____

Duration of symptoms:
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? (Check ONE) ☐ seconds ☐ minutes ☐ hours
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 all the time.
- ☐ 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 motion.
- ☐ in relation to only certain head 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 the dizziness go away? (sit, lay down, close eyes…)
Please explain:
_____

_____

Check 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

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

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

- ☐ loss of consciousness
- ☐ seizures or convulsions
- ☐ slurring of speech
- ☐ difficulty swallowing
- ☐ weakness in one hand, arm, or leg
- ☐ double vision
- ☐ spots before eyes
- ☐ occasional loss of vision
- ☐ sever pounding headache or migraine
- ☐ palpitation of the heartbeat
- ☐ tingling around mouth
- ☐ 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
- ☐ A neck and/or back injury
- ☐ Allergies

Please check below for any MEDICATIONS you have tried FOR DIZZINESS or are currently taking:

Medicine	**Taken in Past**	**Taking Now**	**Helps**
Antivert (Meclizine)			
Valium (Diazepam)			
Dyazide "water pills"			

Have you ever been previously evaluated for dizziness? ☐ **No** ☐ **Yes:** _____

_____