Dizziness History Questionnaire

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

Duration of symptoms:
Currently, my dizziness…

____is constant.
____is always there, but changes in intensity.
____come 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 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:_____

_____

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 type symptoms shortly before the onset of your dizziness?	YES	NO
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?	YES	NO
If you had head trauma prior to your dizziness, did you lose consciousness completely?	YES	NO
Were you exposed to any irritating fumes, paints, etc. at the onset of your 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
____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?_____

_____