DIZZINESS QUESTIONNAIRE

Name		Date
		PLEASE ANSWER ALL QUESTIONS
		"dizzy" do you experience any of the following sensations? PLEASE READ THE ENTIRE LIST FIRST. ther the first line for YES or the second line for NO to describe your feelings most accurately.
YES	NO	
		Lightheadedness
		Swimming sensation in the head
		Blacking out
		Loss of consciousness
		Tendency to fall: To the right?
		To the left?
		Forward?
		Backward?
		Objects spinning or turning around you
		Sensation that you are turning or spinning inside, with outside objects remaining stationary
		Loss of balance when walking: Veering to the right?
		Veering to the left?
		Headache
		Nausea or vomiting
		Pressure in the head
Please	e check	line for either YES or NO and fill in the blank spaces.
YES	NO	
		Are you dizzy all the time?
		Does your dizziness occur in attacks?
		If in attacks: How often?
		How long do they last?
		When did the dizziness first occur?
		Can you tell when an attack is about to start?
		If so, how?
		Are you completely free of dizziness between attacks?
		Does change of position make you dizzy?
		Do you have trouble walking in the dark?
		When you are dizzy, can you stand up unsupported?
		Do you know of any possible cause of your dizziness?
		What?

\/F0	NO	Do you know of anything that will:
YES	NO	Stop your dizziness or make it better? What?
		Make your dizziness worse? What?
		Bring on an attack? What?
		Is there any relationship between eating and your dizziness?
		If so, what?
		Do you eat three meals a day?
		Do you think you eat a lot of animal fat?
		Were you exposed to any irritating fumes, paints, etc. at the onset of your dizziness?
		Do you have any allergies? What?
		Did you ever injure your head?
		Were you unconscious? How long?
		Do you take any medications regularly?
		What?
		Do you use tobacco in any form?
		How much?
		Do you think you are under any unusual strain or tension?
		Has anyone in your family had similar dizziness?
Do yo	u have a	any of the following symptoms? Check either YES or NO and CIRCLE the ear involved. Difficulty in hearing? Both ears Right Left Noise in your ears? Both ears Right Left Describe the noise
		Does noise change with dizziness? If so, how?
		Fullness, stuffiness or pressure in your ears? Both ears Right Left Does this change when you are dizzy? Pain in your ears? Both ears Right Left
		Discharge from your ears? Both ears Right Left Have you ever been exposed to loud noise?
		When? How long?
		Did you wear sound protection?
		Has anyone in your family had a hearing problem?

YES NO In episodes Double vision Constant Blurred vision Constant In episodes Blindness Constant In episodes Numbness of your face Constant In episodes Weakness in your arms or legs In episodes Constant Clumsiness in your arms or legs In episodes Constant Mental confusion In episodes Constant Loss of consciousness Constant In episodes In episodes Difficulty with speech Constant Difficulty with swallowing Constant In episodes HAVE YOU ANSWERED EACH QUESTION EITHER YES OR NO? Is there anything else that you feel may be important for us to know?

Have you experienced any of the following symptoms? Please check either YES or NO and CIRCLE either CONSTANT

or IN ÉPISODES.