

Hearing Professionals, Inc.

Dizziness Questionnaire

Name _____ Date _____

Referring Doctor _____ PCP _____

Other Doctors/Specialists _____

PLEASE ANSWER ALL QUESTIONS

**When you are dizzy, do you experience any of the following sensations?
Please read the entire list first, then either answer YES or NO.**

- Yes No 1. Lightheadedness
- Yes No 2. Swimming sensation in the head
- Yes No 3. Blacking out
- Yes No 4. Loss of consciousness
- Yes No 5. Tendency to fall:
 - To the RIGHT
 - To the LEFT
 - Forward
 - Backward
- Yes No 6. Objects spinning or turning around you
- Yes No 7. You are turning or spinning inside, but objects remain stationary
- Yes No 8. Loss of balance when walking:
 - Veering to the RIGHT
 - Veering to the LEFT
- Yes No 9. Migraines
- Yes No 10. Nausea or vomiting
- Yes No 11. Pressure in the head
- Yes No 12. Motion sickness/ intolerance

Please check either YES or NO and fill in any blank spaces.

- Yes No 1. Is your dizziness constant?
- Yes No 2. Does your dizziness occur in attacks?
 - How often? _____
 - How long do the spells last? _____
 - When did the dizziness first occur? _____
 - When was your last occurrence/episode? _____
 - How severe is your dizziness? (Circle any that apply)
Mild Moderate Severe Getting better Getting worse Staying the same
- Yes No 3. Can you tell when an attack is about to start?
 - If so, how? _____
- Yes No 4. Are you completely free of dizziness between attacks?
- Yes No 5. Does a change of position make you dizzy?

- []Yes []No 6. Do you have trouble walking in the dark?
- []Yes []No 7. Does your vision change when looking to the right/left/up/down?
- []Yes []No 8. Does the room feel like it needs to 'catch up' if you turn quickly?
- []Yes []No 9. Do you know of any possible causes of your dizziness?
- []Yes []No 10. Do you know of anything that makes your dizziness:
Worse? _____
Better? _____
- []Yes []No 11. Is there any relationship between eating and dizziness?
If so, what? _____
- []Yes []No 12. Were you exposed to any irritating fumes, paints, etc. at the
onset of your dizziness?
- []Yes []No 13. Do you have allergies? List: _____
- []Yes []No 14. Did you ever injure your head?
- []Yes []No 15. Were you ever unconscious?
- []Yes []No 16. Do you take medications regularly?
If so, what are they? _____
- []Yes []No 17. Do you use tobacco in any form?
If so, what? _____
- []Yes []No 18. Do you use contraceptives or Hormone Replacement Therapy?
(women only) Please specify: _____
- []Yes []No 19. Have you had recent tests (MRI, CT, etc) Which? _____
Please list any other medical issues we should be aware of _____

Do you have any of the following symptoms? Check either YES or NO, circle in which ear those symptoms occur, and fill in any blanks.

- []Yes []No 1. Difficulty hearing in noise
RIGHT ear LEFT ear BOTH ears
- []Yes []No 2. Noise or ringing (tinnitus) in your ears
RIGHT ear LEFT ear BOTH ears
Describe the noise _____
- []Yes []No 3. Does the noise change with dizziness?
If so, how? _____
- []Yes []No 4. Fullness or stuffiness in your ears
RIGHT ear LEFT ear BOTH ears
- []Yes []No 5. Pain in your ears
RIGHT ear LEFT ear BOTH ears
- []Yes []No 6. Discharge from your ears
RIGHT ear LEFT ear BOTH ears

Have you experienced any of the following symptoms? Check either YES or NO and CONSTANT or IN EPISODES.

- | | |
|--|-------------------------|
| []Yes []No 1. Double vision | []Constant []Episodes |
| []Yes []No 2. Blurred vision or blindness | []Constant []Episodes |
| []Yes []No 3. Numbness in your face | []Constant []Episodes |
| []Yes []No 4. Numbness of your arms or legs | []Constant []Episodes |
| []Yes []No 5. Weakness in your arms or legs | []Constant []Episodes |
| []Yes []No 6. Clumsiness in your arms or legs | []Constant []Episodes |
| []Yes []No 7. Confusion or loss of consciousness | []Constant []Episodes |
| []Yes []No 8. Difficulty with speech | []Constant []Episodes |
| []Yes []No 9. Difficulty swallowing | []Constant []Episodes |