HEARING PROFESSIONALS
DOCTORS OF AUDIOLOGY
PERSONALIZED HEARING CARE & BALANCE CENTER

Dizziness Questionnaire

Name _____ Date _____
Referring Doctor _____ PCP _____
Other Doctors/Specialists _____

PLEASE ANSWER ALL QUESTIONS
Please read the entire list first, and then either answer YES or NO.

When you are dizzy, do you experience any of the following sensations?		
Yes	No	Lightheadedness
Yes	No	Swimming sensation in the head
Yes	No	Blacking out
Yes	No	Loss of consciousness
Yes	No	Tendency to fall: [ ] *To the RIGHT* [ ] *To the LEFT* [ ] *Forward* [ ] *Backward*
Yes	No	Objects spinning or turning around you
Yes	No	You are turning or spinning inside, but objects remain stationary
Yes	No	Loss of balance when walking: [ ] *Veering to the RIGHT* [ ] *Veering to the LEFT*
Yes	No	Migraines
Yes	No	Nausea or vomiting
Yes	No	Pressure in the head
Yes	No	Motion sickness/ intolerance
Please circle either YES or NO. If yes, fill in any blank spaces.		
Yes	No	Is your dizziness constant?
Yes	No	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? (Check any that apply) [ ] Mild [ ] Moderate [ ] Severe [ ] Getting better [ ] Getting worse [ ] Staying the same
Yes	No	Can you tell when an attack is about to start? If so, how?
Yes	No	Are you completely free of dizziness between attacks?
Yes	No	Does a change of position make you dizzy?
Yes	No	Do you have trouble walking in the dark?
Yes	No	Does your vision change when looking to the right/left/up/down?
Yes	No	Does the room feel like it needs to 'catch up' if you turn quickly?
Yes	No	Do you know of any possible causes of your dizziness?
Yes	No	Do you know of anything that makes your dizziness: Worse?_____ Better?_____

Yes	No	Is there any relationship between eating and dizziness? If so, what?
Yes	No	Were you exposed to any irritating fumes, paints, etc. at the onset of your dizziness?
Yes	No	Do you have allergies? If so List:
Yes	No	Did you ever injure your head?
Yes	No	Were you ever unconscious?
Yes	No	Do you take medications regularly? If so, what are they?
Yes	No	Do you use tobacco in any form? If so, what?
Yes	No	Do you use contraceptives or Hormone Replacement Therapy? (women only) Please specify:
Yes	No	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? Circle either YES or NO. If yes, check which ear the symptoms occur and answer any associated questions.		
Yes	No	Difficulty hearing in noise: [ ] *RIGHT ear* [ ] *LEFT ear* [ ] *BOTH ears*
Yes	No	Noise or ringing (tinnitus) in your ears: [ ] *RIGHT ear* [ ] *LEFT ear* [ ] *BOTH ears* Describe the noise:
Yes	No	Does the noise change with dizziness? If so, how?
Yes	No	Fullness or stuffiness in your ears: [ ] *RIGHT ear* [ ] *LEFT ear* [ ] *BOTH ears*
Yes	No	Pain in your ears: [ ] *RIGHT ear* [ ] *LEFT ear* [ ] *BOTH ears*
Yes	No	Discharge from your ears: [ ] *RIGHT ear* [ ] *LEFT ear* [ ] *BOTH ears*
Have you experienced any of the following symptoms? Circle YES or NO If yes, circle CONSTANT or IN EPISODES.		
Yes	No	Double vision: Constant In Episodes
Yes	No	Blurred vision or blindness: Constant In Episodes
Yes	No	Numbness in your face: Constant In Episodes
Yes	No	Numbness of your arms or legs: Constant In Episodes
Yes	No	Weakness in your arms or legs: Constant In Episodes
Yes	No	Clumsiness in your arms or legs: Constant In Episodes
Yes	No	Confusion or loss of consciousness: Constant In Episodes
Yes	No	Difficulty with speech: Constant In Episodes
Yes	No	Difficulty swallowing: Constant In Episodes