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**

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you have cold, flu, or virus type symptoms shortly before the onset of your dizziness?</td>
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<tr>
<td>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?</td>
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<td>If you had head trauma prior to your dizziness, did you lose consciousness completely?</td>
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<td>Were you exposed to any irritating fumes, paints, etc. at the onset of your dizziness?</td>
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<td>Do you get dizzy when you have not eaten for a long time?</td>
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<td>Is your dizziness connected with your menstrual period?</td>
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<td>Did you get new glasses recently?</td>
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<td>I consider myself to be an anxious or tense type of person…</td>
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<td>I am under a great deal of stress…</td>
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**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
- ___ severe 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:

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Taken in Past</th>
<th>Taking Now</th>
<th>Helps</th>
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</thead>
<tbody>
<tr>
<td>Antivert (Meclizine)</td>
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<td>Valium (Diazepam)</td>
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<td>Dyazide “water pills”</td>
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**Have you ever been previously evaluated for dizziness?** _________________________________