Dizziness Questionnaire

Na	Name:					
Date: _		Phone #:				
I.		When you are dizzy, do you experience any of the that describe your feelings most accurately.	following sensations? Circle the terms			
		Light headedness (especially when you stand or sit Sensation that you are turning Headache Sensation that things are turning around you Nausea or vomiting Dizziness occurs in attacks Pressure in the head Dysequilibrium – sensation of falling to one side Spinning Other (please specify):				
ІІ.	1.	How often do the attacks occur?	not, does it come in attacks? Yes/No ow long are the attacks?			
	5.	Describe the first episode of dizziness:				
	6. 7. 8. 9.		ircle which side: right/left			
	10.	 i. Stop your dizziness or make it better ii. Make your dizziness worse? If so, iii. Bring on an attack? If so, what? (exertion, certain foods, etc) b. Did you ever injure your head? If so when and how 	what? kamples: stress, menstrual period,			

- 11. Do you take any medications regularly?
 - i. Allergy pills? Yes/Noii. Decongestants? Yes/NoTranquilizers? Yes/NoPain pills? Yes/No
 - iii. Antihistamines? Yes/No Antibiotics? Yes/No iv. Aspirin? Yes/No Dizziness pills? Yes/No
 - v. High blood pressure meds? Yes/No
- 12. Have you had any intravenous (IV) antibiotics or chemotherapy?
- 13. Do you suffer easily from motion sickness?
- 14. Do you experience migraines?
- 15. Do you have neck/back discomfort or injury?
- 16. Circle any that apply:
- 17. Vision problems? heart problems? High blood pressure? diabetes?
- III. Check the appropriate box if you have had any of the following:

	RIGHT EAR	LEFT EAR	BOTH EARS
Hearing loss			
Difference in pitch of sounds			
Distortion of hearing			
Noise in ears			
Fullness or pressure in your ear			
Pain in your ear			
Drainage from your ear			
	RIGHT EYE	LEFT EYE	BOTH EYES
Blurred vision			
Double vision			
	RIGHT	LEFT	BOTH
Numbness in hands or feet			
Weakness in arms or legs			
	YES	NO	
Tingling around mouth or face			
Loss of consciousness or blackouts			
Fainting			
Convulsion or seizure			
Hyperventilate before symptoms			

IV. Vertigo Functional Level Scale:

to change some plans and make some allowance for my dizziness.

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	best choice that best applies regarding your current state of overall function, ring attacks:
1. My dizzir	ness has no effect on my activities at all.
resume activities. I	m dizzy I have to stop what I am doing for a while, but it soon passes and I car continue to work, drive, and engage in any activity I choose without ot changed any plans of activities to accommodate my dizziness.
3. When I as	m dizzy, I have to stop what I am doing for a while, but it does pass and I can

resume activities. I continue to work, drive, and engage in most activities I choose, but I have had

4. I am able to work, drive, travel, take care of a family, or engage in most activities, but I must exert a great deal of effort to do so. I must constantly make adjustments in my activities and budget my energies. I am barely making it.
5. I am unable to work, drive, or take care of a family. I am unable to do most of the active things that I used to. Even essential activities must be limited. I am disabled.
6. I have been disabled for 1 year or longer and/or I receive compensation (money) because of my dizziness or balance problem.
Any other information we didn't ask about that you would like us to know about your condition: