

Eastern Oklahoma Ear, Nose & Throat, Inc.
Dizziness Questionnaire

Name _____ Date _____

1. When you are “dizzy” do you experience any of the following sensations? Please read the entire list first. Then circle “Yes” or “No” to describe your feelings most accurately.

- | | | |
|-----|----|--|
| Yes | No | 1. Lightheadedness or swimming sensation in the head? |
| Yes | No | 2. Blacking out or loss of consciousness? |
| Yes | No | 3. Tendency to fall: To the right? |
| Yes | No | To the left? |
| Yes | No | Forward? |
| Yes | No | Backward? |
| Yes | No | 4. Objects spinning or turning around you? |
| Yes | No | 5. Sensation that you are turning or spinning inside, with outside objects remaining stationary? |
| Yes | No | 6. Loss of balance when walking: Veering to the right? |
| Yes | No | Veering to the left? |
| Yes | No | 7. Headache? |
| Yes | No | 8. Nausea or vomiting? |
| Yes | No | 9. Pressure in the head? |

2. Please circle “Yes” or “No” and fill in the blank spaces. Answer all questions.

- | | | |
|-----|----|--|
| | | 1. My dizziness is: |
| Yes | No | Constant? |
| Yes | No | In attacks? |
| | | 2. When did dizziness first occur? _____ |
| | | 3. If in attacks, how often? _____ |
| | | How long do they last? _____ |
| | | When was last attack? _____ |
| Yes | No | Do you have any warning that the attack is about to start? |
| Yes | No | Do they occur at any particular time of day or night? |
| Yes | No | Are you completely free of dizziness between attacks? |

- Yes No 4. Does change of position make you dizzy?
- Yes No 5. Do you have trouble walking in the dark?
- Yes No 6. When you are dizzy, must you support yourself when standing?
- Yes No 7. Do you know of any possible cause of your dizziness? What? _____
8. Do you know of anything that will:
- Yes No Stop your dizziness or make it better? _____
- Yes No Make your dizziness worse? _____
- Yes No Precipitate an attack? (Fatigue? Exertion? Hunger?
Menstrual Period? Stress? Emotional Upset?)
- Yes No 9. Were you exposed to any irritating fumes, paints, etc. at the onset of
dizziness?
- Yes No 10. Are you allergic to any medications? Please list _____

- Yes No 11. If you ever injured your head, were you unconscious?
- Yes No 12. If you take any medications regularly, for any reason, please list:

- Yes No 13. Do you use tobacco in any form? How much? _____

3. Do you have any of the following symptoms? Please circle "Yes" or "No" and circle the ear(s) involved.

- | | | | | | |
|-----|----|---|-----------|-------|------|
| Yes | No | 1. Difficulty in hearing? | Both ears | Right | Left |
| Yes | No | 2. Noise in your ears? | Both ears | Right | Left |
| | | Describe the noise _____ | | | |
| Yes | No | Does noise change with dizziness? If so, how? _____ | | | |
| Yes | No | 3. Fullness or stuffiness in your ears? | Both ears | Right | Left |
| Yes | No | 4. Pain in your ears? | Both ears | Right | Left |
| Yes | No | 5. Discharge from your ears? | Both ears | Right | Left |

4. Have you experienced any of the following symptoms? Please circle “Yes” or “No” and circle if “Constant” or “In Episodes”.

Yes	No	1. Double vision, blurred vision or blindness?	Constant	In Episodes
Yes	No	2. Numbness of face?	Constant	In Episodes
Yes	No	3. Numbness of arms or legs?	Constant	In Episodes
Yes	No	4. Weakness in arms or legs?	Constant	In Episodes
Yes	No	5. Clumsiness of arms or legs?	Constant	In Episodes
Yes	No	6. Confusion or loss of consciousness?	Constant	In Episodes
Yes	No	7. Difficulty with speech?	Constant	In Episodes
Yes	No	8. Difficulty with swallowing?	Constant	In Episodes
Yes	No	9. Pain in the neck or shoulder?	Constant	In Episodes