DIZZINESS QUESTIONNAIRE

Rocky Mountain Ear, Nose, & Throat Center, P.C.
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(406) 541-3277 (EARS) or 1 800-255-8698

Patient Name: ____ **Date:** ____________________________

1. When you are "dizzy," do you experience any of the following sensations? Please read the entire list first. Then put an X in the first box for YES or the second box for NO to describe your feelings most accurately.

YES	NO	
☐	☐	1. Sensation that you are turning or spinning inside, with objects remaining stationary.
☐	☐	2. Visual blurring or jumping during head motion.
☐	☐	3. Objects spin or turn around you with your eyes opened.
☐	☐	4. Objects spin or turn around you with your eyes closed.
☐	☐	5. Loss of balance when walking: Veering to the right?
☐	☐	Veering to the left?
☐	☐	6. Tendency to fall: To the right?
☐	☐	Roll to right?
☐	☐	Forward?
☐	☐	Backward?
☐	☐	7. Spinning or turning sensation when you: Lie down?
		Roll to right?
		Roll to left?
		Look up, look down, bend over?
☐	☐	8. Swimming sensation in your head.
☐	☐	9. Spinning sensation in your head.
☐	☐	10. Lightheadedness.
☐	☐	11. Loss of equilibrium/unsteadiness.
☐	☐	12. Blacking out/fainting.
☐	☐	13. Loss of consciousness.
☐	☐	14. Headache or head pressure.
☐	☐	15. Nausea or vomiting.

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

YES	NO	
☐	☐	1. My dizziness is… Constant.
☐	☐	In attacks.
☐	☐	2. When did dizziness first occur? ______________________________
☐	☐	3. If in attacks: How often?______________________________
☐	☐	How long do they last?______________________________
☐	☐	Do you have any warning that the attack is about to start?
☐	☐	4. Are you completely free of dizziness between attacks?
☐	☐	5. Does dizziness occur only in certain positions?
☐	☐	6. Do you have trouble walking in the dark?
☐	☐	7. When you are dizzy, must you support yourself when standing?
☐	☐	8. Do you know of any possible cause of your dizziness?
		If **YES**, what?______________________________
☐	☐	9. Do you know of anything that will: Stop the dizziness or make it better?
☐	☐	Make your dizziness worse?
☐	☐	Cause an attack?

(CONTINUED)

YES	NO	
☐	☐	10. Were you exposed to any irritating fumes, paints, etc. at the onset of dizziness?
☐	☐	11. Do you have any allergies?
☐	☐	12. Did you ever injure your head?
☐	☐	If **YES**, were you unconscious?
☐	☐	13. Do you take any medications regularly?
		If **YES**, what?______________________________
☐	☐	14. Do you use tobacco in any form? How much?______________________
☐	☐	15. Do you use alcohol? How much?______________________________
		16. How many cups of regular coffee, tea, or colas do you drink each day?__________
☐	☐	17. Have you ever had ear surgery?

III. Do you have any of the following symptoms? Put an X in the first box for YES or the second box for NO and circle ear involved.

YES	NO				
☐	☐	1. Difficulty in hearing?	**Both Ears**	**Right**	**Left**
		When did this start?______________________________			
		Is it getting worse?______________________________			
		Does your hearing fluctuate?______________________________			
		Do you wear hearing aids?______________________________			
☐	☐	2. Noise in your ears?	**Both Ears**	**Right**	**Left**
		Describe the noise.______________________________			
☐	☐	Does noise change with dizziness? If so, how?______________________________			
☐	☐	3. Fullness or stuffiness in your ears?	**Both Ears**	**Right**	**Left**
		Does this change when you are dizzy?			
☐	☐	4. Pain in your ears?	**Both Ears**	**Right**	**Left**
☐	☐	5. Drainage from your ears?	**Both Ears**	**Right**	**Left**
☐	☐	6. Distortion of sound?	**Both Ears**	**Right**	**Left**
☐	☐	7. Sensitivity to sound?	**Both Ears**	**Right**	**Left**
☐	☐	8. Feeling of drainage in your ears?	**Both Ears**	**Right**	**Left**

IV. Have you ever experienced any of the following symptoms? Put an X in the first box for YES or the second box for NO and circle if constant or if in episodes.

YES	NO			
☐	☐	1. Double vision.	**Constant**	**In episodes**
☐	☐	2. Spots before your eyes.	**Constant**	**In episodes**
☐	☐	3. Cloudiness of vision.	**Constant**	**In episodes**
☐	☐	4. Numbness of face or extremities.	**Constant**	**In episodes**
☐	☐	5. Blurred vision or blindness.	**Constant**	**In episodes**
☐	☐	6. Weakness or clumsiness in arms or legs.	**Constant**	**In episodes**
☐	☐	7. Difficulty with speech.	**Constant**	**In episodes**
☐	☐	8. Difficulty with swallowing.	**Constant**	**In episodes**
☐	☐	9. Tingling around your mouth	**Constant**	**In episodes**
☐	☐	10. Visual blurring or jumping with head motion.	**Constant**	**In episodes**

V. Please check either YES or NO

YES	NO	
☐	☐	1. Do you get dizzy after exertion or overwork?
☐	☐	2. Did you get new glasses recently?
☐	☐	3. Do you tend to get upset easily?
☐	☐	4. Do you get dizzy when you have not eaten for a long time?
☐	☐	5. Is your dizziness connected with your menstrual period or fluid retention?
☐	☐	6. Have you ever had a neck injury?
☐	☐	7. Are you a diabetic? Insulin ______________ Pill ______________
☐	☐	8. Do you have high blood pressure? Medication ______________
☐	☐	9. Do you have a heart condition? Medications ______________