

## DIZZINESS QUESTIONNAIRE

Please complete ALL sections of this questionnaire. Thank you.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Gender:      Male                       Female

**Is your dizziness constant or does it come in spells?**

It is constant.....

It comes in spells.....

During your dizziness, do you feel like...	Yes	No
You are spinning around in circles.....	<input type="checkbox"/>	<input type="checkbox"/>
The world is spinning around you.....	<input type="checkbox"/>	<input type="checkbox"/>
You are nauseated.....	<input type="checkbox"/>	<input type="checkbox"/>
Your head is swimming.....	<input type="checkbox"/>	<input type="checkbox"/>
You are very sensitive to light, or changes in lighting.....	<input type="checkbox"/>	<input type="checkbox"/>
You are very sensitive to sounds, or changes in sound.....	<input type="checkbox"/>	<input type="checkbox"/>
If yes,		
Do sounds make you dizzy.....	<input type="checkbox"/>	<input type="checkbox"/>
Do sounds make your world jiggle.....	<input type="checkbox"/>	<input type="checkbox"/>

My hearing...	One ear	Both ears	Neither
Changed for the better recently.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changed for the worse recently.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changed during a dizziness attack.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

My ears...	One ear	Both ears	Neither
Ring when I am dizzy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel full or bursting when I am dizzy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Feel painful when I am dizzy.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you...	Yes	No
Lost consciousness, "blacked out," or fainted.....	<input type="checkbox"/>	<input type="checkbox"/>
Had severe prolonged nausea and/or light sensitivity.....	<input type="checkbox"/>	<input type="checkbox"/>
Or a family member ever been diagnosed with migraines.....	<input type="checkbox"/>	<input type="checkbox"/>
Had trouble walking in the dark.....	<input type="checkbox"/>	<input type="checkbox"/>

**If your dizziness comes in spells, please answer the following questions:**

**My typical dizzy attack lasts...(pick ONE)**

- Less than 3 mins.....
- More than 3 but less than 15 mins.....
- More than 15 but less than 59 mins.....
- More than 1 hour but less than 12 hours.....
- More than 12 hours but less than 1 week.....
- Weeks to months.....
- They vary greatly.....

**Usually, a dizzy attack happens...(pick ONE)**

- Less than once a month.....
- At least once a month, but less than weekly.....
- At least once a week, but not daily.....
- Daily.....
- It varies greatly.....

**Which of the following describe your symptoms?**

- |  | <b>Yes</b>               | <b>No</b>                |
|--|--------------------------|--------------------------|
| Dizzy in sudden spells, with breaks in between.....                              | <input type="checkbox"/> | <input type="checkbox"/> |
| Dizzy when sitting or standing still.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Dizzy when rolling over in bed.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Dizzy when turning or moving your head.....                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Dizzy when bent over or reaching down.....                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Dizziness lasts for a few seconds when you get up quickly from a chair<br>or bed | <input type="checkbox"/> | <input type="checkbox"/> |

**Please indicate whether your dizziness changes...**

- |  | <b>More</b>              | <b>Less</b>              | <b>No change</b>         |
|--|--------------------------|--------------------------|--------------------------|
| In certain positions.....                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| For women, during your menstrual period..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| When you sit or stand still.....             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| When you rapidly move your head.....         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |