

# Dizziness Questionnaire

If your problem is tinnitus only answer questions 4, 8, 9 and 10.

If your problem is dizziness please fill out the entire form.

Your Name \_\_\_\_\_

- 1) Describe your major problem or the reason why you are seeing us.
  
- 2) Dizzy means different things to everyone. What is the main type of dizziness that you experience? **Please indicate only one.**
  1. Spinning
  2. Off Balance
  3. Light headedness (if the sensation got worse you might pass out)
  4. Rocking
  5. Other \_\_\_\_\_
  
- 3) When did your problem begin?
  
- 4) What might have caused the problem to begin? Stress? Accident? Infection?
  
- 5) Do you have spells    Yes    No    (circle)
  
- 6) How long does the dizziness last? If your dizzy is spinning then how long does the spinning part last? (Note: if you get several episodes in one day each lasting 20 seconds the answer would be 20 seconds). **THIS IS EXTREMELY IMPORTANT**
  1. Less than 1 minute
  2. 1-5 minutes
  3. minutes to hours
  4. Days
  5. Constant (this means your dizziness **NEVER** stops)
  
- 7) What do you personally think your problem is due to?

**Do you have:**

**YES    NO**

- |   |       |       |
|---|-------|-------|
| 8) Difficulty with your hearing? Which ear?                         | _____ | _____ |
| 9) Pain, fullness, popping or pressure in ear (which ear?)          | _____ | _____ |
| 10) Ringing in ears (called tinnitus)                               | _____ | _____ |
| If you answered yes, please answer the following questions.         |       |       |
| How often?  |       |       |
| How long does it last?  |       |       |
| Is it in the <u>left</u> <u>right</u> or <u>both</u> ears. (circle) |       |       |
| Is it steady or is it pulsating.                                    |       |       |
| 11) Have you stopped working because of your dizziness? If so when? |       |       |

**Continue on back (only if dizzy)**

| <b>To what extent is your dizziness or imbalance affected or brought on by:</b>                                | <u>SEVERELY</u> | <u>MODERATELY</u> | <u>NOT AT ALL</u> |
|--|-----------------|-------------------|-------------------|
| (Check one answer for each question.)  |                 |                   |                   |
| Turning or rolling over in bed   | _____           | _____             | _____             |
| Standing up quickly  | _____           | _____             | _____             |
| Bending over, looking up   | _____           | _____             | _____             |
| Rapid head movements   | _____           | _____             | _____             |
| Walking in the dark  | _____           | _____             | _____             |
| Uneven surfaces (e.g. grass or sand)   | _____           | _____             | _____             |
| Elevators, escalators, stairs  | _____           | _____             | _____             |
| Moving objects, lights and<br>windshield wipers, TV or movies  | _____           | _____             | _____             |
| Shopping malls, narrow or<br>wide open spaces, supermarket   | _____           | _____             | _____             |
| Loud noises  | _____           | _____             | _____             |
| Cough, sneeze, strain, laugh,<br>scuba diving  | _____           | _____             | _____             |
| Exercise (e.g., aerobics, jogging)   | _____           | _____             | _____             |
| Eating, missing meals, special foods,  | _____           | _____             | _____             |
| Heat, hot showers, or cold   | _____           | _____             | _____             |
| Swallowing   | _____           | _____             | _____             |
| Alcohol or caffeine  | _____           | _____             | _____             |
| Airplane, boat or car travel   | _____           | _____             | _____             |
| Depression, anxiety, nerves, or stress   | _____           | _____             | _____             |
| Time of day  | _____           | _____             | _____             |
| Moving your eyes with head still   | _____           | _____             | _____             |
| Are you dizzy with eyes closed   | _____           | _____             | _____             |
| Touching your ears   | _____           | _____             | _____             |
| Tunnels, bridges, heights  | _____           | _____             | _____             |
| Thinking about going to specific<br>places or being in situations that have<br>produced dizziness in the past. | _____           | _____             | _____             |
| Salt, sugar, monosodium glutamate (MSG)  | _____           | _____             | _____             |
| Menstrual periods  | _____           | _____             | _____             |
| Other (specify)  | _____           | _____             | _____             |