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DIZZINESS/VERTIGO QUESTIONNAIRE

Name: _____ Date: _____

SECTION 1: When you are "dizzy" do you experience any of the following sensations? Please read the ***entire list first***. Then tic **YES** or **NO** to describe your feelings most accurately.

O YES O NO 1. Lightheadedness or swimming sensation in the head?
O YES O NO 2. Objects spinning or turning around you?
O YES O NO 3. Sensation that you are turning or spinning inside, with outside objects remaining stationary?
O YES O NO 4. Feeling of tilting, rocking, tumbling or cartwheeling? (Circle applicable symptoms)
O YES O NO 5. Loss of balance when walking: □Veering to the right?
O YES O NO □Veering to the left?
O YES O NO 6. Blacking out or loss of consciousness:
O YES O NO 7. Tendency to fall: To the right?

	To the left?	O YES	O NO
	Forward?	O YES	O NO
	Backward?	O YES	O NO
O YES O NO 8. Headache? If Yes,	Do bright lights bring on headaches?	O YES	O NO
	Loud noises?	O YES	O NO
	Strong smells?	O YES	O NO
	Motion?	O YES	O NO

O YES O NO 9. History of migraine headache?
O YES O NO 10. Family history of migraine headaches?

SECTION 2: Please tic **YES** or **NO** and fill in the blank spaces. Answer all questions.
My dizziness is:
O YES O NO Constant?
O YES O NO In attacks?
When did the dizziness first occur? _____
If in attacks:

1. How often? _____
2. How long do they last? _____
3. When was the last attack? _____

O YES O NO 4. Do you have any warning that the attack is about to start?
O YES O NO 5. Do they occur at any particular time of the day or night?
O YES O NO 6. Are you completely free of dizziness between attacks?
O YES O NO 7. Do changes of position make you dizzy?
O YES O NO 8. Do you have trouble walking in the dark?
O YES O NO 10. Do you know of any possible cause for your dizziness? What?

_____

11. Do you know of anything that will:
    Stop your dizziness or make it better?
    _____
    Make your dizziness worse?
    _____
    Precipitate an attack?
    _____
    (**Fatigue? Exertion? Hunger? Menstrual Cycle? Stress? Emotional Upset?**)

O YES O NO 12. Were you exposed to any irritating fumes, paints, etc. at the onset of your symptoms?
O YES O NO 13. If you ever injured your head, were you unconscious?
O YES O NO 14. Does your voice echo in your ears?
O YES O NO 15. Do you hear your footsteps?
O YES O NO 16. Do you hear your eyeballs move?
O YES O NO 17. Do you find hair brushing or showering too loud?
O YES O NO 18. Do sounds seem too loud?
O YES O NO 19. Do loud sounds cause vertigo?
O YES O NO 20. Does nose blowing/sneezing/coughing bring on vertigo?
O YES O NO 21. Does heavy lifting or straining cause vertigo?
O YES O NO 22. Does exercise/physical exertion bring on dizziness?
YES O NO 23. Do you hear ear noises timed with your heartbeat?

SECTION 3: Do you have any of the following symptoms: Please tic **YES** or **NO** and circle ear involved.
O YES O NO 1. Difficulty hearing? □Both □Right □Left
O YES O NO 2. Noise in your ears? □Both □Right □Left
Describe the noise

_____

O YES O NO Does the noise change with dizziness? If so, how?

_____

O YES O NO 3. Fullness or pressure in your ears? □Both □Right □Left
O YES O NO 4. Pain in your ears? □Both □Right □Left
O YES O NO 5. Discharge from your ears? □Both □Right □Left
O YES O NO 6. Do you use hearing aid? □Both □Right □Left

SECTION 4: LIFE STYLE

How much do you smoke per day? _____
How much salt do you use on your food? _____
How much alcohol do you drink per week? _____
O YES O NO Do you commonly eat chocolate?
O YES O NO Do you eat much food with MSG?
O YES O NO Do you eat much aged cheese?
What sort of work do you do (or used to do)? _____
How often do you fly on airplanes? _____
O YES O NO Are you presently in litigation or planning litigation about symptoms related to your visit?
O YES O NO Are you disabled due to your condition?
(Women of childbearing age only) are you:
OYES O NO Pregnant?
OYES O NO Perimenopausal?

SECTION 5: Have you experienced any of the following symptoms? Please tic **YES** or **NO** and tic if constant or in episodes
O YES O NO 1. Double vision, blurred vision or blindness? Constant Episodes
O YES O NO 2. Numbness of face? Constant Episodes
O YES O NO 3. Numbness of arms or legs? Constant Episodes
O YES O NO 4. Weakness in arms or legs? Constant Episodes
O YES O NO 5. Clumsiness of arms or legs? Constant Episodes
O YES O NO 6. Confusion or loss of consciousness? Constant Episodes
O YES O NO 7. Difficulty with speech? Constant Episodes
O YES O NO 8. Difficulty with swallowing? Constant Episodes
O YES O NO 9. Pain in the neck or shoulder? Constant Episodes