



EAR INSTITUTE OF TEXAS

Dizziness Questionnaire



When evaluating symptoms of dizziness, patient history and description of the symptoms is extremely important in making a correct diagnosis. Please mark all answers that apply and fill in the appropriate blanks:

YES NO QUALITY

1. What describes your dizziness symptoms?
- a) spinning vertigo
 - b) lightheadedness / wooziness
 - c) imbalance / troubles walking / trouble standing
 - veering to the (circle): left right
 - falling (circle): to the right to the left forward backward
 - d) delayed focusing of visual fields / visual blurring during head motion
 - e) blacking out. If yes, do you lose consciousness? (circle): yes no

DURATION, TIMING, AND CONTEXT

2. When did your dizziness first occur? _____
3. When did the most recent dizziness episodes start to occur? _____
4. Is the dizziness constant or recurrent? (circle): constant recurrent
6. How long do the episodes last? (provide range): _____ seconds minutes days
7. How often do the episodes occur? (provide range): _____ per day week month

SEVERITY

8. How would you rate the severity of the dizziness on a scale of 1 to 10 (10 is most severe)? _____ / 10
9. Has the dizziness been changing? (circle): getting better getting worse staying the same

MODIFYING FACTORS

10. Is the dizziness triggered by rapid movements of the head or body? If yes, indicate which movements trigger the symptoms (circle all that apply):
- getting out of bed
 - lying down
 - looking up
 - turning head to the right
 - turning head to the left
 - bending over
 - rolling to the right in bed
 - rolling to the left in bed
 - ALL rapid head movements
11. Do you know of anything that triggers the dizziness episodes? If yes, circle all that apply:
- caffeine
 - salt
 - other dietary items
 - stress/fatigue
 - emotional changes
 - allergies
 - Other: _____
12. Do you know of anything that makes your dizziness better? If yes, what? _____
13. Do you have trouble walking in the dark?
14. Do you require assistance when walking? (circle): companion cane walker
15. Did you suffer a cold, flu, or other infectious symptoms at the time the dizziness began?
16. Have you suffered head trauma or concussion?
17. Have you ever suffered a stroke or TIA (mini-stroke)?

ASSOCIATED SIGNS AND SYMPTOMS

18. Do you experience ear ringing with your dizziness? If yes, which ear? (circle): left right
19. Do you suffer hearing loss with your dizziness? If yes, which ear? (circle): left right
20. Do you suffer pressure in your ears with your dizziness? If yes, which ear? (circle): left right
21. Do you experience nausea or vomiting with the dizziness?
22. Do you suffer from recurrent headaches or pressure in the head? If yes, location: _____
23. Do the headaches occur at the same time as the dizziness?
24. Are your headaches associated with any of the following symptoms? If yes, circle all that apply:
- throbbing head pain
 - moderate or severe head pain
 - nausea or vomiting
 - visual spots/squiggly lines
 - sensitivity to bright lights
 - sensitivity to loud noise

OTHER

25. Have you seen any other doctors for evaluation of this problem? (name) _____
26. Have you been diagnosed with a specific ear or balance problem? _____
27. Have you had other tests completed? If yes, circle all that apply:
- hearing testing
 - balance testing
 - MRI scan of the brain
 - CT scan of the brain
 - carotid ultrasound
 - heart testing

NAME: _____ **SIGN:** _____ **DATE:** _____