EAR CONSULTANTS OF GEORGIA

DIZZINESS QUESTIONNAIRE

I. When you are dizzy do you experience any of the following sensations? Please read the entire list first. Then put an "X" in either 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?
☐	☐		To the left?
☐	☐		Forward?
☐	☐		Backward?
☐	☐	7. Spinning or turning sensation when:	You lay down?
			Roll to the right?
			Roll to the left?
			Look up or down?
☐	☐	8. Swimming sensation in your head.	
☐	☐	9. Spinning sensation in your head.	
☐	☐	10. Lightheadedness	
☐	☐	11. Loss of equilibrium	
☐	☐	12. Blacking out	
☐	☐	13. Loss of consciousness	
☐	☐	14. Headache or head pressure	
☐	☐	15. Nausea or vomiting	

II. Please check box for 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. Does dizziness occur only in certain positions?	
☐	☐	5. Do you have trouble walking in the dark?	
☐	☐	6. When you are dizzy, must you support yourself when standing?	
☐	☐	7. Do you know of any possible cause of your dizziness?	
		What_____	
		8. Do you know of anything that will:	
☐	☐	stop your dizziness or make it better?	
☐	☐	make your dizziness worse?	
☐	☐	cause an attack?	
☐	☐	9. Were you exposed to any irritating fumes, paints, etc., at the onset of dizziness?	
☐	☐	10. Do you have any allergies?	
☐	☐	11. Did you ever injure your head?	
☐	☐	12. Do you take any medications regularly (i.e. tranquilizers, oral contraceptives, barbiturates, antibiotics)?	
		What?_____	
☐	☐	13. Do you use tobacco in any form? How much?_____	
☐	☐	14. Do you use alcohol? How much?_____	
		15. How many cups of regular coffee, tea, or colas do you drink each day?_____	

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

YES	NO				
☐	☐	1. Difficulty in hearing	Both ears	Right	Left
		When did this start?_____			
☐	☐	Is it getting worse?			
☐	☐	2. Noise in your ears?	Both ears	Right	Left
		Describe the noise:_____			
☐	☐	Does noise change with dizziness? If so, how?_____			
☐	☐	Does anything stop the noise or make it better?_____			
☐	☐	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 within your ear?	Both ears	Right	Left
☐	☐	9. Have you ever had ear surgery?	Both ears	Right	Left

IV. Have you ever experienced any of the following symptoms? Put an "X" in either 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 the 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 the mouth	Constant	In Episodes
☐	☐	10. Visual blurring or jumping with head motion	Constant	In Episodes

V. Please check box for 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? Medications:_____
☐	☐	9. Do you have a heart condition? Medications:_____