Shasta ENT Specialists
Redding SINUS Center
George H. Domb, M.D.

Name: _____ Date: _____

DIZZINESS QUESTIONNAIRE

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

Yes No Lightheadedness or swimming sensation in the head.
Yes No Blacking out or loss of consciousness.
Yes No Tendency to fall to the right? _____ Left? _____ Backward? _____
Yes No Objects spinning or turning around you.
Yes No Sensation that you are turning or spinning inside, with outside objects remaining still?
Yes No Loss of balance when walking?
Veering to the right?____Veering to the Left?___
Yes No Headache.
Yes No Nausea or vomiting.
Yes No Pressure in the head.

Please circle **YES** or **NO** and fill in the blank spaces. Answer all questions.

Yes No My dizziness is constant.
Yes No My dizziness comes in attacks.
When did the dizziness first occur? _____
If in attacks, how often? _____
How long do they last? _____
Do you have any warning that the attack is about to start?_____
When was the last attack? _____
Yes No Do you have any warning that the attack is about to start?
Yes No Do they occur at any particular time of the day or night?
Yes No Are you completely free of dizziness between attacks?
Yes No Does change of position make you dizzy?
Yes No Do you have any trouble walking in the dark?
Yes No When you are dizzy, must you support yourself when standing?
Yes No Do you know of any possible cause of you dizziness?

DIZZINESS QUESTIONNAIRE

Yes No Do you get dizzy when you get up from bed?
Yes No Is there any position that will provoke dizziness?
Yes No Do you know of anything that will:
Stop your dizziness or make it better? _____
Make your dizziness worse? _____
Precipitate an attack:
Fatigue? _____ Exertion? _____ Hunger? _____ Stress? _____
Menstrual Period? _____ Emotional Upset? _____
Yes No Were you exposed to any irritating fumes, paints, etc. at the onset of your dizziness?
Yes No If you ever injured your head, were you unconscious?
Yes No Do you suffer from neck pain or pain on the back of the head?
Yes No Do you use tobacco in any form? _____How much? _____

Do you have any of the following symptoms? **Please circle yes or no and the ear involved.**

Yes	No	Difficulty in hearing?	Right	Left	Both Ears
Yes	No	Noise in your ears?	Right	Left	Both Ears
		Describe the noise_____			
Yes	No	Does the noise change with dizziness? If so, how?_____			
		_____			
Yes	No	Fullness or stuffiness in ears?	Right	Left	Both Ears
Yes	No	Pain in your ears?	Right	Left	Both Ears
Yes	No	Discharge from your ears?	Right	Left	Both Ears

Have you experienced any of the following symptoms? Please circle **YES** or **NO** and if **constant** or in **episodes**.

Yes	No	Double vision, blurred vision or blindness	Constant	Episodes
Yes	No	Numbness of face.	Constant	Episodes
Yes	No	Numbness of arms and legs.	Constant	Episodes
Yes	No	Weakness in arms or legs.	Constant	Episodes
Yes	No	Clumsiness of arms or legs.	Constant	Episodes
Yes	No	Confusion or loss of consciousness.	Constant	Episodes
Yes	No	Difficulty with speech.	Constant	Episodes
Yes	No	Difficulty with swallowing.	Constant	Episodes
Yes	No	Pain in the neck or shoulder.	Constant	Episodes