CHESAPEAKE SPECIALTY CARE
CHESAPEAKE ENT ALLERGY AUDIOLOGY

Patient name: _____

DOB: _____

Today's date: _____

Dizziness Questionnaire

1) a) When did your dizziness symptoms begin?

   b) When was your most recent attack?

2) When you are "dizzy," do you experience any of the following? (please check all that apply)

☐ Lightheadedness	☐ Numbness/tingling in your feet
☐ Swimming sensation in your head	☐ Numbness/tingling in your hands
☐ Loss of balance or unsteadiness	☐ Nausea/vomiting
☐ Sensation that you are spinning or turning	☐ Changes in vision
☐ Headaches or migraines	☐ Pressure in your head
☐ Feeling like you're on a boat	☐ Fainting/loss of consciousness

3) Do you have ear symptoms?

☐ Hearing loss or changes in hearing
☐ right ear ☐ left ear ☐ both ☐ not sure

☐ Tinnitus (ringing, buzzing, hissing in your ears)
☐ right ear ☐ left ear ☐ both ☐ not sure

☐ Pressure/fullness in your ears
☐ right ear ☐ left ear ☐ both ☐ not sure

☐ Have you had hearing testing in the past?
☐ yes ☐ no

4) Please describe your first episode (without using the word "dizzy" or "vertigo"):

5) Is your dizziness ☐ constant ☐ in attacks or episodes

6) How long do your episodes of dizziness last?
☐ less than a minute ☐ more than a minute ☐ 10-30 minutes
☐ 30-60 minutes ☐ several hours ☐ days

7) How often do these episodes occur?
☐ Daily ☐ Weekly ☐ Monthly ☐ Other:

8) Do you have any warning signs that your episode is going to occur? ☐ Yes ☐ No
If yes, please specify:

9) Are you completely free of dizziness between episodes? ☐ Yes ☐ No

10) What activities **decrease** your dizziness symptoms (please check all that apply)?
☐ Lying ☐ Sitting ☐ Standing ☐ Sleeping ☐ Medication ☐ Other:

11) What activities **increase** your dizziness symptoms (please check all that apply)?
☐ Lying ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Looking up and/or down
☐ Turning your head to the right or left ☐ Other:

Please complete page 2.

Dizziness Questionnaire Cont

Name: _____

12) Does rolling over and/or sitting up in bed make you feel dizzy? ☐ Yes ☐ No If yes, which direction is worse? ☐ right side ☐ left side ☐ not sure
13) Since it started, has your dizziness gotten ☐ better ☐ worse ☐ stayed the same
14) Have you fallen as a result of your dizziness? ☐ Yes ☐ No Do you have a tendency to fall ☐ to the right ☐ to the left ☐ forward ☐ backward ☐ not sure
15) Have you suffered from recent head trauma or upper respiratory infection? ☐ Yes ☐ No
16) Did you travel on a boat/cruise before your dizziness began? ☐ Yes ☐ No
17) Do you suffer from seasonal/environmental allergies? ☐ Yes ☐ No If yes, what medications do you take? Please list:
18) Do you have high/low blood pressure? ☐ High ☐ Low ☐ Neither If yes, is it controlled by medication? ☐ Yes ☐ No
19) Do you have difficulty/pain moving your head or neck? ☐ Yes ☐ No
20) Do you have cataracts or lens implants? ☐ Yes ☐ No
21) Do you drink alcohol? ☐ Yes ☐ No If yes, how often?
22) Do you engage in recreational drug use? ☐ Yes ☐ No
23) Do you use tobacco products? ☐ Yes ☐ No
24) a) Have you seen a medical provider for your dizziness? ☐ Yes ☐ No If yes, where were you seen? b) Were you given medication/s for your dizziness? ☐ Yes ☐ No If yes, please list: c) Did the medication help? ☐ Yes ☐ No
25) Have you had any diagnostic testing (e.g. bloodwork, MRI, CT, etc.) since your dizziness began? ☐ Yes ☐ No If yes, where was the imaging done?