HEAD AND NECK SURGERY ASSOCIATES
DIZZINESS QUESTIONNAIRE

Name: Date:

When did the dizziness first occur: **Please check the answer**

- ❑ Few days ago
- ❑ Few weeks ago
- ❑ Few months ago
- ❑ Years ago, how many? _____

Date

My dizziness is constant	**No**	**Yes**		
My dizziness is in attacks	**No**	**Yes**		
If "Yes," how many times per day _____				
How many times per week _____				
How long do they last seconds min. hours.				
Do you have any warning that the attack is about to start	**No**	**Yes**		
Are you completely free of dizziness between attacks	**No**	**Yes**		
Does dizziness occur when sitting	**No**	**Yes**		
Does dizziness occur when standing	**No**	**Yes**		
Does dizziness occur when laying down	**No**	**Yes**		
Does dizziness occur when going from sitting to standing position	**No**	**Yes**		
Does dizziness occur when looking up	**No**	**Yes**		
Does dizziness occur when bending over	**No**	**Yes**		
Does dizziness occur when turning your head to the right	**No**	**Yes**		
Does dizziness occur when turning your head to the left	**No**	**Yes**		
Do you get dizzy after exertion	**No**	**Yes**		
Do you have pain in your ears	**No**	**Both ears**	**Right ear**	**Left ear**
Do you have discharge from your ears	**No**	**Both ears**	**Right ear**	**Left ear**
Do you have difficulty hearing	**No**	**Both ears**	**Right ear**	**Left ear**
Fullness or stuffiness in your ears	**No**	**Both ears**	**Right ear**	**Left ear**
Does this change when your are dizzy	**No**	**Yes**		

Have you ever experienced these symptoms? If "YES" circle "Constant" or "In Episodes"

Double vision	**No**	**Yes**	Constant	In Episodes
Numbness of face or extremities	**No**	**Yes**	Constant	In Episodes
Blurred vision or blindness	**No**	**Yes**	Constant	In Episodes
Weakness in arms or legs	**No**	**Yes**	Constant	In Episodes
Confusion	**No**	**Yes**	Constant	In Episodes
Difficulty with swallowing	**No**	**Yes**	Constant	In Episodes
Tingling around the mouth	**No**	**Yes**	Constant	In Episodes
Spots before the eyes	**No**	**Yes**	Constant	In Episodes

When you are "dizzy" do you experience any of the following sensations?

Lightheadedness	**No**	**Yes**
Swimming sensation in the head	**No**	**Yes**
Blacking out	**No**	**Yes**
Loss of consciousness	**No**	**Yes**
Tendency to fall to the right	**No**	**Yes**
Tendency to fall to the left	**No**	**Yes**
Tendency to fall forward	**No**	**Yes**
Tendency to fall backward	**No**	**Yes**
Objects spinning or turning around you	**No**	**Yes**
Sensation that you are turning or spinning inside, with outside objects remaining stationary	**No**	**Yes**
Loss of balance when walking, veering to the right	**No**	**Yes**
Loss of balance when walking, veering to the left	**No**	**Yes**
Headache	**No**	**Yes**
Nausea or vomiting	**No**	**Yes**
Pressure in the head	**No**	**Yes**
Were you seen by your doctor or an hospital emergency room	**No**	**Yes**
If "Yes," which one		
Were you given any medication	**No**	**Yes**
If "Yes," what is the name of the medication		
Do you get dizzy when you have not eaten for a long time	**No**	**Yes**
(Females) Is your dizziness connected with your menstrual period	**No**	**Yes**
If "Yes," is it : ❑ prior to your menstrual period ❑ during your menstrual period		
Have you ever had seizures of any type	**No**	**Yes**
Have you ever have a head injury	**No**	**Yes**
If "Yes," would you consider it serious	**No**	**Yes**
Have you ever have a serious neck injury	**No**	**Yes**
Have you ever had ear surgery	**No**	**Yes**
Do you know any possible cause of your dizziness	**No**	**Yes**
If "Yes," list possible causes:		
Will anything stop your dizziness or make it better	**No**	**Yes**
If "Yes," list what stops your dizziness:		
Does anything make your dizziness worse	**No**	**Yes**
If "Yes," list what makes it worse:		
Have you had any of these tests ordered for your dizziness **❑ CT scan ❑ MRI ❑ X-ray ❑ Lab work** If you checked any of the above: **Where was it done:** **When was it done:**		