DIZZINESS STUDY

Name _____ **Date** _____

PLEASE ANSWER ALL QUESTIONS

I. When you are "dizzy", do you experience any of the following sensations? PLEASE READ THE ENTIRE LINE 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.	Lightheadedness
☐	☐	2.	Swimming sensation in the head
☐	☐	3.	Blacking out
☐	☐	4.	Loss of consciousness
☐	☐	5.	Tendency to fall: To the right?
☐	☐		To the left?
☐	☐		Forward?
☐	☐		Backward?
☐	☐	6.	Objects spinning or turning around you?
☐	☐	7.	Sensation that you are turning or spinning inside, with outside objects remaining stationary?
☐	☐	8.	Loss of balance when walking: Veering to the right?
			Veering to the left?
☐	☐	9.	Headache
☐	☐	10.	Nausea or vomiting
☐	☐	11.	Pressure in the head

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.	If in attacks: How often? _____
			How long do they last? _____
		3.	When did dizziness first occur? _____
☐	☐	4.	Can you tell when an attack is about to start?
☐	☐	5.	Are you completely free of dizziness between attacks?
☐	☐	6.	Does change of position make you dizzy?
☐	☐	7.	Do you have trouble walking in the dark?
☐	☐	8.	When you are dizzy, can you stand unsupported?
☐	☐	9.	Do you know of any possible cause of your dizziness?
			What? _____

YES	NO		
		10.	Do you know of anything that will:
☐	☐		Stop your dizziness or make it better?
☐	☐		Make your dizziness worse?
☐	☐		Precipitate an attack?
☐	☐	11.	Were you exposed to any irritating fumes, paints, etc. at the
☐	☐	12.	Do you have any allergies?
☐	☐	13.	Did you ever injure your head?
☐	☐		Were you unconscious?
☐	☐	14.	Do you take any medications regularly?
			What? _____
☐	☐	15.	Do you use tobacco in any form?
			How much? _____

III. Do you have any of the following symptoms? Check either YES or NO and CIRCLE ear involved:

YES	NO					
☐	☐	1.	Difficulty in hearing?	Both ears	Right	Left
☐	☐	2.	Noise in your ears?	Both ears	Right	Left
			Describe the noise			
			Does the noise change with dizziness. If so, how?			
			_____			
☐	☐	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.	Discharge from your ears?	Both ears	Right	Left

IV. Have you experienced any of the following symptoms? Please check either YES or NO and CIRCLE either CONSTANT or IN EPISODES.

YES	NO				
☐	☐	1.	Double vision	Constant	In episodes
☐	☐	2.	Numbness in face or extremities	Constant	In episodes
☐	☐	3.	Blurred vision or blindness	Constant	In episodes
☐	☐	4.	Weakness in arms or legs	Constant	In episodes
☐	☐	5.	Clumsiness in arms or legs	Constant	In episodes
☐	☐	6.	Confusion or loss of consciousness	Constant	In episodes
☐	☐	7.	Difficulty with speech	Constant	In episodes
☐	☐	8.	Difficulty with swallowing	Constant	In episodes