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## DIZZINESS QUESTIONNAIRE

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Doctor \_\_\_\_\_

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

- YES  NO 1. Lightheaded.
- YES  NO 2. Swimming sensation in the head.
- YES  NO 3. Blacking out.
- YES  NO 4. Loss of consciousness.
- YES  NO 5. Tendency to fall: To the right?
- YES  NO To the left?
- YES  NO Forward?
- YES  NO Backward?
- YES  NO 6. Objects spinning or turning around you.
- YES  NO 7. Sensation that you are turning or spinning inside, with outside objects remaining stationary.
- YES  NO 8. Loss of balance when walking: Veering to the right?
- YES  NO Veering to the left?
- YES  NO 9. Headache.
- YES  NO 10. Nausea or vomiting.
- YES  NO 11. Pressure in the head.

II. Please check the box for either "YES" or "NO" and fill in the blank spaces.

YES NO

- YES  NO 1. Is dizziness constant?
- YES  NO in attacks?
- YES  NO 2. When did the dizziness first occur? \_\_\_\_\_
- YES  NO 3. If in attacks: How often? \_\_\_\_\_
- YES  NO How long do they last? \_\_\_\_\_
- YES  NO Do you have any warning that the attack is about to start?
- YES  NO 4. Are you completely free of dizziness between attacks?
- YES  NO 5. Does dizziness occur only in certain positions?
- YES  NO 6. Do you have trouble walking in the dark?
- YES  NO 7. When you are dizzy, must you support yourself when standing?
- YES  NO 8. Do you know of any possible cause of your dizziness?
- YES  NO What? \_\_\_\_\_
- YES  NO 9. Do you know of anything that will:
- YES  NO Stop your dizziness or make it better?
- YES  NO Make you dizziness worse?
- YES  NO Precipitate an attack?

YES NO

- 10. Were you exposed to any irritating fumes, paint, etc. at the onset of dizziness?
- 11. Do you have any allergies?
- 12. Did you ever injure your head?  
Were you unconscious?
- 13. Do you take any medications regularly? (i.e. tranquilizers, oral contraceptives, barbiturates, antibiotics). What? \_\_\_\_\_
- 14. Do you use tobacco in any form? How much? \_\_\_\_\_
- 15. Do you use alcohol?
- 16. Have you ever had ear surgery?

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 circle the ear involved.

YES NO

- 1. Difficulty on hearing?      Both ears                  Right                  Left  
When did this start? \_\_\_\_\_
- 2. Noise in you ears?                  Both ears                  Right                  Left  
Describe the noise \_\_\_\_\_
- Does the noise change with dizziness? If so, how? \_\_\_\_\_
- Does anything stop the noise or make it better?
- 3. Fullness or stiffness 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 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. Numbness of the face and 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
- 9. Tingling around mouth.                  Constant                  In Episodes
- 10. Spots before the eyes.                  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?
- 6. Have you ever had a neck injury?