DIZZINESS QUESTIONNAIRE

Name _____

Date _____

Date the dizziness or balance disturbance began:_____

Describe initial attack: _____

Description of present symptoms (Check those that are similar to yours)

_____ **Spinning** _____ **Off-Balance**

_____ **Woozy** _____ **"Drunk-Like"**

_____ **Rocking** _____ **Light Headed**

_____ **Other:** _____

How long does the dizziness last? (Check one)

_____ **Seconds** _____ **Days**

_____ **Minutes** _____ **Constant**

_____ **Hours** _____ **Varies**

How often does the dizziness occur: (Please choose one and fill in blank)

_____ **Times per day** _____ **Times per week**

_____ **Times per month** _____ **Constant**

How Does the dizziness limit your activities? (Circle all that apply)

Driving Working Exercise Computer TV Reading

Other (describe) _____

Other Symptoms associated with your dizziness (circle)

Yes	**No**	**Hearing Loss**	**Right**	**Left**
Yes	**No**	**Ear or Head noises**	**Right**	**left**
Yes	**No**	**Numbness – where?**_____		
Yes	**No**	**Paralysis – where?** _____		
Yes	**No**	**Headache – where?** _____		
Yes	**No**	**Blurred or double vision**		
Yes	**No**	**Slurred Speech**		
Yes	**No**	**Nausea and Vomiting**		
Yes	**No**	**Confusion**		
Yes	**No**	**Blackouts or loss of consciousness**		
Yes	**No**	**Increase heart rate**		
Yes	**No**	**Increase breathing rate**		
Yes	**No**	**Panic Attacks**		
Yes	**No**	**Memory Loss**		