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Ear, Nose, Throat • Head and Neck Surgery • Otology
Cosmetic Facial Plastic Surgery • Audiology

DIZZINESS QUESTIONNAIRE

Patient Name**:** Date**:**

You have indicated you have vertigo, imbalance or dizziness problems. Answer the following questions by circling the appropriate bold response or answering in the blank space provided.

1. My first dizzy attack occurred_____ . My most recent dizzy attack occurred_____.

2. I **can** / **cannot** tell an attack is about to begin. If you can tell, how far ahead can you tell?_____.

3. Which of the following most closely resembles your problem? Mark as many as apply.

- ☐ A whirling or spinning sensation where your surroundings, you, or both move.
- ☐ Imbalance without a sensation of motion that:
  - ☐ Causes a rocking sensation.
  - ☐ Makes you feel like you veer or are pushed to one side.
  - ☐ Makes you feel like you need extra support.
- ☐ A sense of lightheadedness, giddiness, head swimming, floating.
- ☐ None of the above, more like _____ .

4. I have dizziness **all of the time** / **some of the time** / **once in a while**. Symptoms are **constant** / **fluctuate**.

5. I **have** / **do not have** isolated attacks of vertigo that come _____ times a **week** / **month** / **year**.

6. When attacks occur, the sensation of motion lasts on the average _____ **minutes** / **hours** / **days**. It takes _____ **minutes** / **hours** / **days** for me to completely regain my balance after the motion ceases.

7. When my dizziness occurs, I also experience: (*please circle any that apply*)

Ear Ringing	Ear Fullness	Ear Pressure	Hearing Changes	Sound Distortion
Headache	Visual Changes	Ear Pain	Darkening Vision	Numbness/Tingling
Ear Discharge	Nausea	Vomiting	Problem Working	Difficulty Walking
Falling	Unconsciousness	Other:		

8. What triggers dizziness:_____

9. What makes it worse:_____

10. What makes it better:_____

11. My dizziness **seems** / **does not seem** to be worse at a particular time of year.

12. Certain foods **do** / **do not** trigger or exacerbate my symptoms.

13. Number of physician's seen for your dizzy problems:_____

14. Please circle the following specialties you have seen in the past:

Family Physician	Neurology	ENT Specialist
Neurotologist	Opthalmologist	Psychiatrist

Please give additional information about any of the following tests that you have had

Test Type	**Date and Location**	**Test Type**	**Date and Location**
CT Scan		Audiogram	
MRI Scan		ENG	
Ultrasound		ABR	
Blood Tests		EcoG	
Balance Testing		Other:	

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