



DIZZY QUESTIONNAIRE

NAME: _____

DOB: _____

DATE: _____

Please answer to the best of your ability. All questions may not apply to your symptoms. The audiologist performing your test will discuss your answers in greater detail.

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

YES NO Lightheadedness

YES NO Spinning sensation

YES NO Loss of balance when walking

YES NO Loss of balance to the point of falling

YES NO Nausea or vomiting

YES NO Headache

How would you describe your symptoms without using the word “dizzy”?

My dizziness is:

YES |NO Constant

YES |NO In attacks

When did the dizziness first occur? _____

How long does the dizziness last? Seconds Minutes Hours Days

When was the last attack? _____

YES NO Have you recently had a cold or viral episode

YES NO Are you completely free of dizziness between attacks

YES NO Do changes in position make you dizzy
YES NO Do you have trouble walking in the dark
YES NO Do objects seem to bounce up and down when you walk

Do you know of any possible cause for your dizziness? _____

Do you know of anything that will:

YES NO Make your dizziness better
If yes, what? _____

YES NO Make your dizziness worse
If yes, what? _____

YES NO Do your symptoms seem to be helped by medication?
If yes, what medication? _____

List the medications you are taking and any health issues you may have: _____

Do you have any of the following symptoms?

YES NO Difficulty hearing Both ears RIGHT LEFT

YES NO Noise in your ears Both ears RIGHT LEFT

If yes, does the noise change with your dizziness? Yes No

YES NO Fullness in your ears Both ears RIGHT LEFT

If yes, does it change with your dizziness? Yes No

Have you experienced any of the following?

YES NO Pain in the back or shoulders

YES NO Difficulty with speech or swallowing

YES NO Double vision, blurred vision or blindness