Dizziness History Questionnaire

Name: _____ Date of Birth: _____ Age: _____ Date: _____

When was the first time you ever experienced dizziness? _____

What were you doing when the dizziness started? _____

When was the last time you experienced dizziness? _____

How long does your dizziness last in general? _____

Has the dizziness changed since the first episode? ❑ Yes ❑ No

If yes, ❑better ❑worse ❑shorter ❑longer ❑other: _____

CURRENTLY, MY DIZZINESS:

❑is constant ❑is always there, but changes in intensity ❑comes in episodes

IF YOUR DIZZINESS OCCURS IN EPISODES, (please circle ONE)

How long does it typically last? ____ seconds/minutes/hours/days

How often does it typically occur? ____ times per hour/day/week/month/year

MY EPISODES OCCUR: (please check ALL that apply)

❑ spontaneously
❑ only when standing or walking
❑ in relation to any head motion
❑ when I sit up from bed
❑ when I lay down in bed
❑ only in certain head/body positions.

Please describe: _____

MY DIZZINESS IS BEST DESCRIBED AS: (please check ALL that apply)

❑ spinning sensation ❑ off balanced ❑ swimming sensation
❑ light-headedness ❑ near-faint sensation ❑ other

Please explain: _____

IS THERE ANYTHING THAT YOU CAN DO TO MAKE YOUR DIZZINESS GO AWAY? WORSE? Please explain:

_____

_____

_____

CIRCLE ALL THAT APPLY:

I have hearing difficulty: Right/Left/Both I have ringing or other sounds: Right/Left/Both

I have ear fullness: Right/Left/Both I have ear drainage/discharge: Right/Left/Both

I HAVE OR HAVE HAD: (please check ALL that apply)

❑Diabetes ❑Stroke ❑Neck issues ❑Back issues

❑Neurological conditions ❑High blood pressure ❑Migraine headaches ❑Anxiety/Depression

❑Heart conditions ❑Immunodeficiency ❑Other:_____

IN THE PAST YEAR, I HAVE HAD:

- ❑ loss of consciousness
- ❑ seizures or convulsions
- ❑ slurring of speech
- ❑ difficulty swallowing
- ❑ weakness in one hand, arm or leg
- ❑ double vision
- ❑ spots in vision
- ❑ occasional loss of vision
- ❑ severe pounding headache or migraine
- ❑ heart palpitations
- ❑ tingling around the mouth
- ❑ tendency to fall
- ❑ loss of balance when walking

Does nausea and/or vomiting accompany your dizziness? ❑ Yes ❑ No

Did you have cold, flu or virus symptoms shortly before the onset of your dizziness? ❑ Yes ❑ No

Did you cough, lift, fly in a plane, swim under water or have head trauma shortly before the onset of your dizziness? ❑ Yes ❑ No

Do you consider yourself to be an anxious or tense person? ❑ Yes ❑ No

Do you experience motion sickness, car sickness, air sickness or sea sickness? ❑ Yes ❑ No

Were you exposed to any solvents, chemicals, etc.? ❑ Yes ❑ No

Have you had any injuries to your head? ❑ Yes ❑ No

If so, when? _____

Have you ever fallen? ❑ Yes ❑ No

If so, when? _____ How often? _____

Was it caused by dizziness or imbalance? ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No

Do you smoke? ❑ Yes ❑ No

Do you take illegal drugs? ❑ Yes ❑ No

Do you take any medications regularly? ❑ Yes ❑ No

If so, which medications? _____

Do you take any medications for your dizziness? ❑ Yes ❑ No

If so, which medications? _____

Did/does it help? ❑ Yes ❑ No