Dr Peter Friedland
Adult & Paediatric Ear, Nose and Throat

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Dizziness Questionnaire

Name: ______________________________ Date: ______________

Describing your dizziness

When you are 'dizzy' do you experience any of the following sensations? Please read the entire list first, then tick yes or no to describe your feelings most accurately.

Light-headedness or swimming sensation in the head			☐ Yes	☐ No
Blacking out of loss of consciousness			☐ Yes	☐ No
Tendency to fall			☐ Yes	☐ No
If yes, in which direction?	☐ To the left	☐ To the right	☐ Forward	☐ Backward
Objects spinning or turning around you, sensation that you are turning or spinning inside, with outside objects remain stationary			☐ Yes	☐ No
Sensation of the environment moving up and down while you walk			☐ Yes	☐ No
Loss of balance when walking			☐ Yes	☐ No
Veering to the right			☐ Yes	☐ No
Veering to the left			☐ Yes	☐ No
Headache of pressure in the head			☐ Yes	☐ No
Nausea or vomiting			☐ Yes	☐ No
Palpations, perspiration, shortness of breath or a feeling a panic			☐ Yes	☐ No

Dizziness onset and frequency

When did the dizziness first occur? ______________________________

Is your dizziness constant *or*			☐ Yes	☐ No
Does your dizziness come in attacks?			☐ Yes	☐ No
If your dizziness comes in attacks, how often?	☐ Daily	☐ Weekly	☐ Monthly	☐ Yearly
How long do they last?	☐ Seconds	☐ Minutes	☐ Hours	☐ Days

When was your last attack ______________________________

How do you feel between attacks?	☐ Normal	☐ Off Balance	☐ Dizzy	☐ Light Headed

☐ Other ______________________________

Do you have any warning that the attack is about to start?	☐ Yes	☐ No

If yes, please describe ______________________________

Do they occur at any particular time of the day or night?	☐ Yes	☐ No
Are you completely free of dizziness between attacks?	☐ Yes	☐ No
Does a change of position make you dizzy?	☐ Yes	☐ No

If yes, please describe ______________________________

Do you have trouble walking when dark or need support when standing? ☐ Yes ☐ No

Do you know of any possible causes or trigger of your dizziness? ☐ Yes ☐ No

If yes, please describe ______________________________

Did you experience anything different before the symptoms began? ☐ Yes ☐ No

If yes, please describe (e.g. cold, flu, virus, sore ears, ear infection, head injury, plane trip, swimming, diving)

____

Do you know anything that will;

Stop your dizziness or make it better?	☐ Yes	☐ No
Make you dizziness worse?	☐ Yes	☐ No
Precipitate an attack? (e.g. fatigue, exertion, hunger, menstrual period, stress, emotional)	☐ Yes	☐ No
If you ever injured your head, were you unconscious?	☐ Yes	☐ No

Have you ever received any therapy for this condition? (e.g. medical, alternative, physiotherapy)

If yes, please describe ______________________________

Do you ever have the following symptoms?

Difficulty in hearing		☐ Yes	☐ No
If yes	☐ Both ears	☐ Right	☐ Left
Does it change with your dizziness attacks?		☐ Yes	☐ No
Noise in your ears		☐ Yes	☐ No
If yes	☐ Both ears	☐ Right	☐ Left

How loud is your tinnitus or head noise most of the time? ______________________________

Please describe the noise ______________________________

Does noise change with dizziness, if so, how? ______________________________

Fullness or stuffiness in your ears		☐ Yes	☐ No
If yes	☐ Both ears	☐ Right	☐ Left
Pain in your ears		☐ Yes	☐ No
If yes	☐ Both ears	☐ Right	☐ Left

Do you ever have the following symptoms?

Blurred, loss or double vision	☐ Yes	☐ No	☐ Constant	☐ In episodes
Numbness of face	☐ Yes	☐ No	☐ Constant	☐ In episodes
Numbness of legs	☐ Yes	☐ No	☐ Constant	☐ In episodes
Weakness in arms or legs	☐ Yes	☐ No	☐ Constant	☐ In episodes
Clumsiness of arms or legs	☐ Yes	☐ No	☐ Constant	☐ In episodes
Confusion or loss of memory	☐ Yes	☐ No	☐ Constant	☐ In episodes
Seasickness or car sickness	☐ Yes	☐ No	☐ Constant	☐ In episodes
Visual impairment	☐ Yes	☐ No		

If yes, please describe ______________________________

Do you wear glasses	☐ Yes	☐ No
If yes, have you changed them recently	☐ Yes	☐ No

Other visual impairments ______________________________