CUMBERLAND VALLEY ENT CONSULTANTS

DIZZY QUESTIONNAIRE

NAME: _____ DATE: _____

1) When you are "dizzy", do you experience any of the following sensations? (Check all that apply)
   - ___Light-headedness or swimming sensation in the head?
   - ___Blacking out or loss of consciousness?
   - ___ Objects spinning or swimming around you?
     How long does spinning last?
     _____seconds; _____minutes; _____hours; _____days
   - ___Loss of balance when walking?
   - ___Change in hearing? _____Right; _____Left; _____Both
   - ___Noise in your ears? _____Right; _____Left; _____Both
   - ___Ear Fullness or stuffiness? _____Right; _____Left; _____Both

2) Please check all that apply and answer the corresponding questions:
   - ___My dizziness is: _____constant; _____attacks intermittently
   - ___When did dizziness first occur? _____
   - ___If intermittent attacks: _____how often; _____how long do they last; _____when did last attack occur
   - ___Do episodes occur in certain body positions?
   - ___History of migraines or head trauma?
   - ___Any medications that may contribute to your dizziness?
   - ___History of head MRI? When?

3) Have you experienced any of the following symptom? If yes, is it constant or in episodes? (Check all that apply)
   - ___Double vision, blurred vision or blindness _____Constant; _____Episodes
   - ___Numbness of arms/legs _____Constant; _____Episodes
   - ___Weakness of arms/legs _____Constant; _____Episodes
   - ___Seasickness or car sickness _____Constant; _____Episodes
   - ___Headache?
   - ___Nausea/vomiting?
   - ___Light sensitivity? (e.g. need to be in a darkened room)
   - ___Sound sensitivity?
   - ___Visual sensitivity (e.g. when scrolling on computer or phone screen)?