DIZZINESS QUESTIONNAIRE

Name ______________________________

Date ______________________________

Date the dizziness or balance disturbance began:______________________________

Describe initial attack: ______________________________

Description of present symptoms (Check those that are similar to yours)

_________	**Spinning**	_________	**Off-Balance**
_________	**Woozy**	_________	**"Drunk-Like"**
_________	**Rocking**	_________	**Light Headed**
_________	**Other:** ______________________________		

How long does the dizziness last? (Check one)

_________	**Seconds**	_________	**Days**
_________	**Minutes**	_________	**Constant**
_________	**Hours**	_________	**Varies**

How often does the dizziness occur: (Please choose one and fill in blank)

_________	**Times per day**	_________	**Times per week**
_________	**Times per month**	_________	**Constant**

How Does the dizziness limit your activities? (Circle all that apply)

Driving **Working** **Exercise** **Computer** **TV** **Reading**

Other (describe) ______________________________

Other Symptoms associated with your dizziness (circle)

Yes	**No**	**Hearing Loss**	**Right**	**Left**
Yes	**No**	**Ear or Head noises**	**Right**	**left**
Yes	**No**	**Numbness – where?**______________________________		
Yes	**No**	**Paralysis – where?** ______________________________		
Yes	**No**	**Headache – where?** ______________________________		
Yes	**No**	**Blurred or double vision**		
Yes	**No**	**Slurred Speech**		
Yes	**No**	**Nausea and Vomiting**		
Yes	**No**	**Confusion**		
Yes	**No**	**Blackouts or loss of consciousness**		
Yes	**No**	**Increase heart rate**		
Yes	**No**	**Increase breathing rate**		
Yes	**No**	**Panic Attacks**		
Yes	**No**	**Memory Loss**		