TRI COUNTY EAR, NOSE & THROAT, P.C.

VERTIGO QUESTIONNAIRE

Name: ____

Date: ________________ Age: _____________ Sex: M F

Please read the entire list first. Then check only those answers which describe your feelings most accurately.

I. When you are dizzy; do you experience any of the following sensation?

_____ Lightheadedness

_____ Swimming sensation in the head

_____ Objects spinning or turning around you

_____ Sensation that you are turning or spinning inside

_____ Loss of balance when walking - Veering to right ____ left ____

_____Tendency to fall- right ____ left ____ forward ____ backward ____

_____Blacking out

_____Loss of consciousness

_____Nausea and/or vomiting

_____Headache

_____Sensation of spinning after turning over in bed

II.

1. When did your dizziness first occur? ____
2. Do you know of any possible cause of your dizziness?

   ____
3. Were you exposed to any irritating fumes, paints, etc- at onset of the dizziness?

   ____
4. Did you ever injure your head? Yes ____ No ____
5. How often do attacks occur? ____
6. Is your dizziness constant or does it come in attacks? _________________________________
7. Can you tell when an attack is about to start? Yes ____ No ____
   If yes, how?

   ____

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8. Does change in position make you dizzy? Yes ____ No ____
   If yes, what positions?

   ____

9. When you are dizzy, can you stand unsupported? Yes ____ No ____

10. Do you have any allergies? ____

III. Do you have any of the following symptoms?

1. Difficulty in hearing? _____ No _____ Both ears _____ Right _____ Left
2. Noise in your ears? _____ No _____ Both ears _____ Right _____ Left
3. Pain in your ears? _____ No _____ Both ears _____ Right _____ Left
4. Fullness or stuffiness in your ears? _____ Yes _____ No

   Does this change in any way when you are dizzy? _____ Yes _____ No
5. Drainage from your ears _____ No _____ Both ears _____ Right _____ Left

   When? ____

IV. Have you experienced any of the following symptoms? If so, are they constant or do they come and go?

1. Double/blurred vision or blindness _____ Yes _____ No
   _____ Constant _____ Episodes
2. Numbness of face or extremities _____ Yes _____ No
   _____ Constant _____ Episodes
3. Weakness of arms or legs _____ Yes _____ No
   _____ Constant _____ Episodes
4. Clumsiness of arms or legs _____ Yes _____ No
   _____ Constant _____ Episodes
5. Confusion _____ Yes _____ No
   _____ Constant _____ Episodes
6. Difficulty with swallowing _____ Yes _____ No
   _____ Constant _____ Episodes

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