

When you are “dizzy” do you experience any of the following sensations?

Please read the entire list first.

Circle Yes or No to describe your feelings most accurately.

| | | |
|---|-----|----|
| Lightheadedness or swimming sensation in the head? | Yes | No |
| Blacking out or loss of consciousness? | Yes | No |
| Does print blur with prolonged reading? | Yes | No |
| Objects spinning or turning around you? | Yes | No |
| Sensation that you are turning or spinning inside, with outside objects remaining stationary? | Yes | No |
| Headache? | Yes | No |
| Nausea or vomiting | Yes | No |
| Pressure in the head? | Yes | No |

Please circle Yes or No and fill in the blank spaces.

| | | |
|--|-----|----|
| My dizziness is constant? | Yes | No |
| In attacks / episodes? | Yes | No |
| When did dizziness first occur? | Yes | No |
| If in attacks / episodes, how often? | Yes | No |
| How long do they last? | Yes | No |
| When was your last attack? | Yes | No |
| Do you have any warning that the attack is about to start? | Yes | No |
| Do they occur at any particular time of day or night? | Yes | No |
| Are you completely free of dizziness between attacks? | Yes | No |

Please circle Yes or No and fill in the blank spaces. Answer all questions.

| | | |
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| Does change of position make you dizzy? | Yes | No |
| Does rolling over in bed make you dizzy? | Yes | No |
| Are you dizzy when bending over? | Yes | No |
| Are you dizzy when looking up? | Yes | No |
| When you are dizzy, must you support yourself when standing? | Yes | No |
| Do you get dizzy turning your head quickly? | Yes | No |

| | | |
|--|-----|----|
| Do you know of any possible cause of your dizziness? | | |
| Do you know of anything that will stop your dizziness or make it better? (describe) | | |
| Do you know of anything that will make your dizziness worse? (Describe) | | |
| Do you know of anything that will precipitate an attack? Circle all that apply. Fatigue, exertion, hunger, menstrual period, stress, emotional upset, change in pressure. (describe) | | |
| Do you smoke or use tobacco in any form? How Much? | Yes | No |
| Do you use alcohol? How much? | Yes | No |
| Do you use caffeine (coffee, tea, soda etc.)? How much? | Yes | No |

Do you have any of the following symptoms?
Please circle Yes or No and which ear.

| | | | | |
|------------------------|-----|----|-----------|----------|
| Difficulty in hearing? | Yes | No | Right Ear | Left Ear |
| Noise in your ears? | Yes | No | Right Ear | Left Ear |

| | | | |
|---|-----|----|--|
| Does noise change with dizziness? If so, how? | Yes | No | |
|---|-----|----|--|

| | | | | |
|--------------------------------------|-----|----|-----------|----------|
| Fullness or stuffiness in your ears? | Yes | No | Right Ear | Left Ear |
| Pain in your ears? | Yes | No | Right Ear | Left Ear |
| Discharge from your ears? | Yes | No | Right Ear | Left Ear |

Have you experienced any of the following symptoms?
Please circle Yes or No and circle if Constant or if in Episodes.

| | | | | |
|---|-----|----|----------|----------|
| Double vision, blurred vision or blindness? | Yes | No | Constant | Episodes |
| Numbness of face? | Yes | No | Constant | Episodes |

| | | | | |
|-------------------------------------|-----|----|----------|----------|
| Numbness of arms or legs? | Yes | No | Constant | Episodes |
| Weakness in arms or legs? | Yes | No | Constant | Episodes |
| Clumsiness of arms or legs? | Yes | No | Constant | Episodes |
| Confusion or loss of consciousness? | Yes | No | Constant | Episodes |
| Difficulty with speech? | Yes | No | Constant | Episodes |
| Difficulty with swallowing? | Yes | No | Constant | Episodes |
| Pain in the neck or shoulder? | Yes | No | Constant | Episodes |

| | | | | |
|--|------------|----------|----------|-----------|
| Have you had an MRI or CT scan of the head/neck? | | | Yes | No |
| Do you have any vision problems? | | | Yes | No |
| Please circle all that apply: | Stigmatism | Cataract | Lazy Eye | Blind Eye |
| Have you had any eye surgeries? Please describe. | | | Yes | No |

Have you experience any of the following symptoms?
Please circle Yes / No or Sometimes.

| | | | |
|---|-----|----|-----------|
| Difficulty getting up from sitting? | Yes | No | Sometimes |
| Difficulty getting up from lying down? | Yes | No | Sometimes |
| Difficulty walking in dark rooms? | Yes | No | Sometimes |
| Difficulty getting in or out of the shower or tub? | Yes | No | Sometimes |
| A staggering walk? | Yes | No | Sometimes |
| Difficulty making turns while walking without losing balance? | Yes | No | Sometimes |
| Difficulty walking without holding onto furniture or walls? | Yes | No | Sometimes |
| Difficulty walking on thick carpet? | Yes | No | Sometimes |
| Imbalance walking in grass? | Yes | No | Sometimes |
| Difficulty climbing stairs or ladders? | Yes | No | Sometimes |
| Imbalance walking in a crowded environment? | Yes | No | Sometimes |
| Imbalance in shopping malls or grocery stores? | Yes | No | Sometimes |

| | | |
|--|----------|--------------|
| Is your disequilibrium constant or intermittent? | Constant | Intermittent |
|--|----------|--------------|

If intermittent, how often?

When did this first occur?

When did this last occur?

Do you know of any possible cause of your imbalance?

Do you have any warning when disequilibrium is about to occur?

Please circle Yes or No and fill in the blank Spaces.
Answer all questions.

| | | |
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| Does time of day make a difference? | Yes | No |
|-------------------------------------|-----|----|

| | | |
|------------------------------------|-----|----|
| Do you feel as if you are tilting? | Yes | No |
|------------------------------------|-----|----|

| | |
|--------------|-------------|
| to the right | to the left |
|--------------|-------------|

| | | |
|---------------------------------|-----|----|
| Do you have a tendency to fall? | Yes | No |
|---------------------------------|-----|----|

| | | | |
|-------------|--------------|----------|---------|
| to the left | to the right | Backward | forward |
|-------------|--------------|----------|---------|

| | | |
|---|-----|----|
| Do you have a loss of balance when walking? | Yes | No |
|---|-----|----|

| | |
|-------------------|------------------|
| veer to the right | veer to the left |
|-------------------|------------------|

| | | |
|---------------------------------|-----|----|
| Do you use an assistive device? | Yes | No |
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| | | |
|---|-----|----|
| Does someone frequently accompany you out of doors? | Yes | No |
|---|-----|----|

| | | |
|-------------------------------------|-----|----|
| Are you afraid to go outside alone? | Yes | No |
|-------------------------------------|-----|----|

| | | |
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| Have you suffered from depression, anxiety, nerves or stress lately? | Yes | No |
|--|-----|----|

How often do you fall?

When and how did you last fall?

Please tell me about other falls?

What did you used to be able to do that you cannot do now because of your dizziness / balance problem?
