



**Adult Neurology**

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**Patient Dizziness Questionnaire**

Name \_\_\_\_\_ Date \_\_\_\_\_

1. Which of these best describes your dizziness? Circle only one.

A sensation of movement of yourself or the room: spinning, tilting, or wave-like movement

Lightheadedness or feeling that you are going to faint

Loss of balance

Disassociation or disorientation with the world

2. When you are "dizzy" do you experience any of the following sensations? You may Circle as many yes responses as necessary.

- |     |    |   |
|-----|----|---|
| Yes | No | 1. Lightheadedness or swimming sensation in the head. |
| Yes | No | 2. Blacking out or loss of consciousness.             |
| Yes | No | 3. Tendency to fall.                                  |
| Yes | No | 4. Objects spinning or turning around you.            |
| Yes | No | 5. Sensation that you are turning or spinning inside. |
| Yes | No | 6. Loss of balance when walking.                      |
| Yes | No | 7. Headache   |
| Yes | No | 8. Pressure in the head.                              |
| Yes | No | 9. Nausea or vomiting.                                |

3. Please fill in the blanks or circle appropriate answer

A. When did the dizziness first occur? \_\_\_\_\_

B. Is the dizziness CONSTANT or does it come in ATTACKS?

C. If the dizziness comes in attacks, how often do these attacks occur?  
\_\_\_\_\_ times per day / week / month / year.

D. If the dizziness comes in attacks, how long do the attacks last?  
\_\_\_\_\_ seconds / minutes / hours / days.

E. What factors provoke the dizziness or make the dizziness worse?  
\_\_\_\_\_

F. What makes the dizziness better?  
\_\_\_\_\_

G. Does your hearing change when the dizziness occurs?  
Yes / No                      How? \_\_\_\_\_  
Which Ear?                      Right / Left

H. Are there any other symptoms associated with the dizziness, such as visual  
Changes, numbness or tingling in the arms or legs, weakness in the  
arms or legs, changes in speech?  
\_\_\_\_\_

I. Are you completely free of dizziness between attacks? Circle Yes / No

J. Have you ever been diagnosed with a head or neck injury? Circle Yes / No

K. Do you have any history of a neurological disease such as migraine, Multiple  
Sclerosis or stroke? Circle Yes / No  
Explain \_\_\_\_\_

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

Yes	No	1. Difficulty in hearing?	Right	Left
Yes	No	2. Noise in your ears?	Right	Left
Yes	No	3. Does noise change during the dizziness?How?		
Yes	No	4. Fullness or stuffiness in your ears?	Right	Left

5. Have you experienced any of the following symptoms?

- |     |    |  |
|-----|----|--|
| Yes | No | 1. Double vision, blurred vision or blindness. |
| Yes | No | 2. Numbness of face.                           |
| Yes | No | 3. Numbness of arms or legs.                   |
| Yes | No | 4. Weakness in arms or legs.                   |
| Yes | No | 5. Clumsiness of arms or legs.                 |
| Yes | No | 6. Confusion or loss of consciousness.         |
| Yes | No | 7. Difficulty with speech.                     |
| Yes | No | 8. Difficulty with swallowing.                 |
| Yes | No | 9. Pain in the neck or shoulder.               |