Dizziness Questionnaire

I. Do you experience any of these sensations?

1. Light headedness (especially when you stand or sit up quickly)
   YES/NO
   Remarks:

2. Sensation that you are turning
   YES/NO
   Remarks:

3. Sensation that things are turning around you
   YES/NO
   Remarks:

4. Unable to stand or walk properly without support, veering or staggering to one side
   YES/NO
   Remarks:

5. Headache
   YES/NO
   Remarks:

6. Pressure in the head
   YES/NO
   Remarks:

7. Nausea or vomiting
   YES/NO
   Remarks:

8. Feeling faint, about to black out
   YES/NO
   Remarks:

II. Chronology

1. When did the dizziness first occur (approximate date)? ____________________________
   ____________________________
   ____________________________
   ____________________________
2. Describe the first episode of dizziness: ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________

3. What kind of warning do you have before an attack? ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________

4. Is the dizziness constant or does it come in attacks? ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________

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

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

III. General Pattern

1. What factors provoke the dizziness? ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________

2. Do you know anything that will stop your dizziness? Or make it feel better? Or make it worse? ____________________________________________
   ____________________________________________
   ____________________________________________
   ____________________________________________

3. Does the level of your dizziness vary in severity during working hours when compared to non-working hours? Does the level of your dizziness increase in severity as the day progresses on working days? ____________________________________________
   ____________________________________________
   ____________________________________________
4. Does change in head position provoke an attack of dizziness? _______________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

5. What do you think brings on an attack? ______________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

6. Do you get dizzy after overwork or exertion?
   YES/NO
   Remarks:

7. Do your colleagues report of similar symptoms?
   YES/NO
   Remarks:

8. 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?
   YES/NO
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

IV. Otological

1. Do you feel that your hearing sensitivity is reduced?
   YES/NO
   Remarks:

2. Do you have noise in your ears?
   YES/NO
   Remarks:

V. Health and Habits

1. Do you have any heart diseases?
   YES/NO
   Remarks:
2. Do you have any kidney diseases?
   YES/NO
   Remarks:

3. Do you have diabetes?
   YES/NO
   Remarks:

4. Do you take prescription medications?
   YES/NO
   Remarks:

5. Do you smoke?
   YES/NO
   Remarks:

6. Do you consume alcohol regularly?
   YES/NO
   Remarks:

VI. Vertigo Functional Level Scale

Check the best choice that best applies regarding your current state of overall function, not just during attacks:

1. My dizziness has no effect on my activities at all.

2. When I am dizzy I have to stop what I am doing for a while, but it soon passes and I can resume activities. I continue to work, drive, and engage in any activity I choose without restriction. I have not changed any plans of activities to accommodate my dizziness.

3. When I am dizzy, I have to stop what I am doing for a while, but it does pass and I can resume activities. I continue to work, drive, and engage in most activities I choose, but I have had to change some plans and make some allowance for my dizziness.

4. I am able to work, drive, travel, take care of a family, or engage in most activities, but I must exert a great deal of effort to do so. I must constantly make adjustments in my activities and budget my energies. I am barely making it.

5. I am unable to work, drive, or take care of a family. I am unable to do most of the active things that I used to. Even essential activities must be limited. I am disabled.

Any other information we did not ask about that you would like us to know about your condition

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________

_______________________________________________________________