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Fauquier Ear Nose & Throat Consultants

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DIZZINESS QUESTIONNAIRE

I. When you are “dizzy” do you experience any of the following sensations? Please read the entire list first, then put an “X” in the box for either Yes or No to describe your feelings most accurately.

YES NO

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Lightheadedness. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Swimming sensation in the head. |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Blacking out. |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Loss of consciousness. |
| | | 5. Tendency to fall: |
| <input type="checkbox"/> | <input type="checkbox"/> | To the right? |
| <input type="checkbox"/> | <input type="checkbox"/> | To the left? |
| <input type="checkbox"/> | <input type="checkbox"/> | Forward? |
| <input type="checkbox"/> | <input type="checkbox"/> | Backward? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Objects spinning or turning around you. |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Sensation that you are spinning inside, with outside objects remaining stationary. |
| | | 8. Loss of balance when walking and veering: |
| <input type="checkbox"/> | <input type="checkbox"/> | To the right? |
| <input type="checkbox"/> | <input type="checkbox"/> | To the left? |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Headache. |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Nausea or vomiting. |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Pressure in the head. |

II. Please check the box for either YES or No and fill in all blank spaces.

YES NO

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. My dizziness is constant. |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. My dizziness comes in attacks. |
| | | 3. When did dizziness first occur? _____ |
| | | 4. If in attacks: |
| | | How often are the attacks? _____ |
| | | How long do they last? _____ |
| | | What, if any, warning signs do you have prior to an attack?
_____ |
| | | 5. Does dizziness occur in certain positions? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Are you completely free of dizziness between attacks? |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Do you have trouble walking in the dark? |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. When you are dizzy, must you support yourself when standing? |
| | | 9. Do you know of any possible causes for your dizziness?
Please list: _____ |
| | | 10. Do you know of anything that will : |
| <input type="checkbox"/> | <input type="checkbox"/> | Stop your dizziness or make it better? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Make your dizziness worse? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Precipitate an attack? _____ |

11. Any exposure to any irritating fumes, paints, etc at the onset of your dizziness?
12. Do you have any allergies? _____
13. Please list any medications you take regularly: _____

YES NO

14. Do you use tobacco in any form?
15. Do you use alcohol?

III. Do you have any of the following symptoms? Please mark YES or NO and circle the ear involved.

YES NO

- | | | | | | |
|--------------------------|--------------------------|---------------------------------------|-------|------|-----------|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Have you ever had ear surgery? | Right | Left | Both Ears |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Difficulty in hearing? | Right | Left | Both Ears |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Fluctuating hearing loss? | Right | Left | Both Ears |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Do you have fullness in your ears? | Right | Left | Both Ears |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Do you have pain in your ears? | Right | Left | Both Ears |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Discharge from your ears? | Right | Left | Both Ears |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Do you have noise in your ears? | Right | Left | Both Ears |

Describe the noise if applicable: _____

Does the noise change with dizziness? If so, how? _____

Does anything stop the noise or make it better? _____

8. Have you been exposed to, or work in, excessive loud noise?

IV. Have you ever experienced any of the following symptoms? Please mark YES or NO and circle if your symptoms are Constant or In Episodes.

YES NO

- | | | | | |
|--------------------------|--------------------------|--|----------|-------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Double Vision | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Numbness of face or extremities. | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Blurred vision or blindness. | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Weakness in arms or legs. | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Clumsiness in arms or legs. | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Confusion or loss of consciousness. | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Difficulty with speech. | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Difficulty with swallowing. | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Tingling around the mouth. | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Spots before the eyes. | Constant | In Episodes |

V. Please check box for either YES or NO.

YES NO

1. Do you get dizzy after exertion or overwork?
2. Did you get new glasses / contacts recently?
3. Do you tend to get stressed easily?
4. Do you get dizzy if you have not eaten for a long time?
5. Do you get dizzy when you stand up?
6. Have you ever had a neck or back injury?

13. Does turning over in bed increase your problem?
14. Because of your problem, is it difficult for you to do strenuous house or yard work?
15. Because of your problem, are you afraid people might think you are intoxicated?
16. Because of your problem, is it difficult for you to walk by yourself?
17. Does walking in down a sidewalk increase your problem?
18. Because of your problem, is it difficult for you to concentrate?
19. Because of your problem, is it difficult to walk around your house in the dark?
20. Because of your problem, are you afraid to stay home alone?
21. Because of your problem, do you feel handicapped?
22. Has your problem placed stress on your relationships with family and friends?
23. Because of your problem, are you depressed?
24. Does your problem interfere with your job or household responsibilities?
25. Does bending over increase your problem?