

**RICHARD S. ENG, M.D., INC.**  
*Ear, Nose, & Throat Specialists, Head & Neck Surgery*

**DIZZINESS QUESTIONNAIRE**

**PATIENT'S NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_

**YES**    **NO**

**CHRONOLOGY**

1. When did your dizziness **start**? \_\_\_\_\_
2. If your dizziness comes in **attacks**, how often? \_\_\_\_\_
3. Give (approximate) **dates** of most recent attacks. \_\_\_\_\_
4. How long does an attack **last**? \_\_\_\_\_
5. What kind of "**warning**" do you have before an attack? \_\_\_\_\_
6. Is your dizziness **constant**? \_\_\_\_\_
7. Are you free of dizziness **between attacks**? \_\_\_\_\_
8. Does your dizziness **start** when you **awaken** in the morning? \_\_\_\_\_
9. Do you get **carsick** (especially in the back seats)? Or **seasick**? \_\_\_\_\_
10. Did your dizziness:
  - Come on after **severe flu**? \_\_\_\_\_
  - Follow a recent **airplane trip**? \_\_\_\_\_
  - Follow **swimming** or **diving** or **physical exertion**? \_\_\_\_\_

**GENERAL PATTERN**

1. What **position** provokes an attack? \_\_\_\_\_
2. What do you think **brings on** an attack? \_\_\_\_\_
3. What will:
  - Stop your dizziness?** \_\_\_\_\_
  - Make it feel better?** \_\_\_\_\_
  - Make it worse?** \_\_\_\_\_
4. When you have an **attack**:
  - Do you have a sensation that you are **turning** or **spinning inside**? \_\_\_\_\_
  - Do you have a sensation of **objects spinning** or **turning around you**? \_\_\_\_\_
  - Do you have **nausea** \_\_\_ and/or **vomiting** \_\_\_? \_\_\_\_\_
  - Must you **support yourself** when you are standing? \_\_\_\_\_
  - Do you feel **better** if you **sit** or **lie down**? \_\_\_\_\_
  - Do you feel as if you are **falling**:
    - to the right \_\_\_\_\_, to the left \_\_\_\_\_, forward \_\_\_\_\_, backward \_\_\_\_\_
5. Do you have "**loss of balance**" when walking? \_\_\_\_\_
6. Has there been any dizziness in any **member** of your **family**? \_\_\_\_\_

**HEARING LOSS, TINNITUS, OR EAR DISEASE**

1. Do you have:
  - A draining ear?** \_\_\_\_\_
  - Earaches?** \_\_\_\_\_
  - A feeling of **stiffness** in your **ears** when you have a dizzy spell? \_\_\_\_\_
  - Any **ringing/buzzing/hissing** in either ear? \_\_\_\_\_
  - Any **increase** in **ringing/buzzing/hissing** before or after a dizzy attack? \_\_\_\_\_

YES NO

- 2. Does your **hearing** seem to **change** at times? \_\_\_\_\_
- 3. Have you had any kind of **ear surgery**? \_\_\_\_\_

**OCULAR PROBLEMS**

- 1. Do you ever have **double vision**? \_\_\_\_\_
- 2. Do you have **trouble walking in the dark**? \_\_\_\_\_
- 3. Do you have periods of **blurred vision**? \_\_\_\_\_
- 4. Do you ever have **spots** before your **eyes**? \_\_\_\_\_
- 5. Did you get **new glasses** recently? \_\_\_\_\_

**CNS-ATAXIA PROBLEMS**

- 1. Do you have:
  - Numbness** of the face, arms, or legs? \_\_\_\_\_
  - Weakness** in your arms or legs? \_\_\_\_\_
  - A feeling of **clumsiness** in your arms or legs? \_\_\_\_\_
- 2. Do you **drop** books or dishes **unintentionally**? \_\_\_\_\_
- 3. Do you have **difficulty in speaking**? \_\_\_\_\_
- 4. Is it hard for you to **get words out**, even though you know what you want to say? \_\_\_\_\_
- 5. Do you have **difficulty swallowing**? \_\_\_\_\_
- 6. Do you ever have any **tingling** around your mouth? \_\_\_\_\_
- 7. Have you ever had any **head injury**? \_\_\_\_\_
- Were you **unconscious**? \_\_\_\_\_

**DYSEQUILIBRIUM**

- 1. When you feel dizzy:
  - Are you **lightheaded**? \_\_\_\_\_
  - Do you have a **swimming sensation** in your head? \_\_\_\_\_
  - Do you feel as if you are going to **black out**? \_\_\_\_\_
  - Do you **lose consciousness**? \_\_\_\_\_
  - Do you have a feeling of **pressure in the head**? \_\_\_\_\_
  - Do you have a **headache**? \_\_\_\_\_
  - Do you feel **faint**? \_\_\_\_\_
- 2. Do you get dizzy:
  - When you are **hungry**? \_\_\_\_\_
  - After an **overwork** or **exertion**? \_\_\_\_\_
  - When you **turn over in bed** or when you **first get out of bed**? \_\_\_\_\_
- 3. Do you get **upset** easily and **cry** easily? \_\_\_\_\_
- 4. Have you been under great **emotional stress**? \_\_\_\_\_
- 5. Do you have dizziness related to your **menstrual cycle**? \_\_\_\_\_
- 6. Do you use the **"pill"** (oral contraceptive)? \_\_\_\_\_
- 7. Do you **smoke**? \_\_\_\_\_
- 8. Do you drink **alcohol**? \_\_\_\_\_
- 9. Do you have **high blood pressure**? \_\_\_\_\_
- 10. Are you **anemic**? \_\_\_\_\_
- 11. Are you on **thyroid medication**? \_\_\_\_\_

First Name Last Name D.O.B. DATE