Greater Buffalo centers for Dizziness & Balance
Specialists in Fall Prevention

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Dizziness questionnaire

Please fill out this questionnaire and bring it with you to your appointment.

Name _____ Date _____

I. **Which of these best describes your dizziness? Check 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

II. 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.

III. 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 _____

IV. 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

V. 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.

Thank you for taking the time to fill out this form. The information will be used to help you with your problem.