DIZZINESS STUDY

Name _____ **Date** _____

When you are "dizzy" do you experience any of the following sensations? Please read the entire list first. Place an "X" in either the first column for YES or the second column for NO to describe your feelings accurately. PLEASE RESPOND TO EACH INDIVIDUAL QUESTION.

YES	NO	
		1. Lightheadedness.
		2. Swimming sensation in the head
		3. Blacking out
		4. Loss of consciousness.
		5. Tendency to fall : **To the right To the left Forward Backward**
		6. Objects spinning or turning around you.
		7. Sensation that you are turning or spinning inside, with outside objects remaining stationary.
		8. Loss of balance when walking: **Veering to the right Veering to the left**
		9. Headache.
		10. Nausea or vomiting.
		11. Pressure in the head.

Please check YES or NO and fill in the blank spaces.

YES	NO	
		1. My dizziness is constant.
		2. My dizziness is in attacks. If in attacks, how often? _____ How long do they last?_____
		3. When did dizziness first occur? _____
		4. Can you tell when an attack is about to start?
		5. Are you completely free of dizziness between attacks?
		6. Does change of position make you dizzy?
		7. Do you have trouble walking in the dark?
		8. When you are dizzy, can you stand up unsupported?
		9. Do you know any possible cause of your dizziness? What?_____
		10. Do you know anything that will: Stop your dizziness or make it better? Make your dizziness worse? Precipitate an attack?

DIZZINESS STUDY (CONTINUED):

YES	NO	
		11. Were you exposed to any irritating fumes, paints, etc., at the onset of the dizziness?
		12. Do you have any allergies?
		13. Did you ever injure your head?
		Were you unconscious?
		14. Do you take any medications regularly?
		If so, please list _____
		15. Do you use tobacco in any form?
		If yes, how much?_____

Do you have any of the following symptoms? Check either **YES** or **NO** and circle which ear is involved:

YES	NO				
		1. Difficulty in hearing?	**Both ears**	**Right**	**Left**
		2. Noise in ears?	**Both ears**	**Right**	**Left**
		Describe the noise_____			
		Does noise change with dizziness? If so, how? _____			
		3. Fullness or stuffiness in your ears?	**Both ears**	**Right**	**Left**
		Does this change when you are dizzy?			
		4. Pain in your ears?	**Both ears**	**Right**	**Left**
		5. Discharge from your ears?	**Both ears**	**Right**	**Left**

Have you experienced any of the following symptoms? Please check **YES** or **NO** and circle either **CONSTANT** or **IN EPISODES**.

YES	NO			
		1. Double Vision	CONSTANT	IN EPISODES
		2. Numbness of face or extremities	CONSTANT	IN EPISODES
		3. Blurred Vision	CONSTANT	IN EPISODES
		4. Weakness of arms or legs	CONSTANT	IN EPISODES
		5. Discharge from your ears?	CONSTANT	IN EPISODES
		6. Confusion or loss of consciousness	CONSTANT	IN EPISODES
		7. Difficulty with speech	CONSTANT	IN EPISODES