

DIZZINESS HISTORY QUESTIONNAIRE

Name: \_\_\_\_\_

Age: \_\_\_\_\_ years      Sex: Male/Female (Circle ONE)

I am right-handed/left-handed (Circle ONE)

When is the first time ever in your life you had dizziness?

WHAT were the circumstances? \_\_\_\_\_  
\_\_\_\_\_

Currently my dizziness.... (Check all that apply)

- is constant
- comes and goes
- is always there but waxes and wanes

If it comes and goes:

How long does it typically last? \_\_\_\_\_  
seconds/minutes/hours (Circle ONE)

How often does it typically occur? \_\_\_\_\_ times  
per hour/day/month/year (Circle ONE)

My dizziness mostly consists of (Check ALL that apply)

- spells of spinning with nausea
- off-balance sensation without a dizzy sensation
- a light-headed or near-faint sensation
- other; Please explain: \_\_\_\_\_

Between episodes, I feel (Check ONE):

- dizzy or off-balance all the time
- normal
- other; Please explain \_\_\_\_\_

My episodes occur (Check ALL that apply)

- spontaneously. Nothing I do seems to bring them on or turn them off
- in relation to any head motion
- in relation to only certain head positions

Describe \_\_\_\_\_

Did you cough, lift, sneeze, fly in an airplane, swim under water, or sustain head trauma shortly before the onset of your dizziness?.....YES/NO

If you had head trauma prior to your dizziness, did you lose consciousness completely?.....YES/NO

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When I roll over in bed (Check ONE):

- the room spins every time
- the room seems to spin sometimes
- nothing unusual happens

Circle all that apply:

- I have hearing difficulty..... Left ear/Right ear
- I have ringing or other sounds..... Left ear/Right ear
- I have fullness..... Left ear/Right ear
- I have had ear surgery..... Left ear/Right ear

I consider myself to be an anxious or tense type of person:

- ..... YES/NO
- I am under a great deal of stress..... YES/NO

In the past year I have had (CIRCLE):

- Loss of consciousness..... YES/NO
- Seizure or convulsion..... YES/NO
- Slurring of Speech..... YES/NO
- Weakness in one hand, arm or leg..... YES/NO
- Numbness along one side of my body..... YES/NO
- Double vision..... YES/NO
- Transient loss of vision..... YES/NO
- Severe pounding headache or migraine..... YES/NO
- Palpitations of the heart beat..... YES/NO
- Anxiety attacks..... YES/NO

I have or have had (CIRCLE):

- Diabetes..... YES/NO
- High blood pressure..... YES/NO
- Arthritis..... YES/NO
- Head or neck pain..... YES/NO
- Irregular heart beat..... YES/NO
- Stroke..... YES/NO

Please check below for any **MEDICATIONS** you have tried **FOR DIZZINESS** or are currently taking:

	Taken in past	Taking now	Helps
Antivert (or meclizine)	( )	( )	( )
Valium (or diazepam)	( )	( )	( )
Diazide, "water pills"	( )	( )	( )
Other:	( )	( )	( )

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The effect of Antivert (meclizine) on my dizziness is (Check the ONE that applies):

- |   |   |
|---|---|
| <input type="checkbox"/> Never tried it | <input type="checkbox"/> Helps moderately |
| <input type="checkbox"/> Helps a little | <input type="checkbox"/> No help          |
| <input type="checkbox"/> Helps a lot    | <input type="checkbox"/> Makes it worse   |

Regarding my current state of overall function, not just during attacks (Check the ONE that best applies):

1. My dizziness has no effect on my activities.
2. When I am dizzy I have to stop what I am doing for awhile, but it soon passes and I can keep going. I continue to work, drive, and engage in any activity I choose without restriction and I have not changed any plans or activities to accommodate my dizziness.
3. When I am dizzy I have to stop what I am doing for awhile, but it does pass and I keep going. I continue to work, drive, and engage in most activities I choose, but I have had to make some allowance for my dizziness.
4. I am able to work, drive, travel, take care of my family, or engage in most essential 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 my family. I am unable to do most of the active things I used to do. Even essential activities must be limited. I am disabled.
6. I am unable to walk more than a short distance. Even the simplest activity requires great effort and I am forced to rest afterwards. I cannot take care of my basic needs. I am totally disabled and virtually bedridden.