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 office
( ) 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

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:	( )	( )	( )

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

( ) Never tried it ( ) Helps moderately
( ) Helps a little ( ) No help
( ) Helps a lot ( ) 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.