

**HOUSE EAR CLINIC, INC.**  
2100 West Third Street, 1<sup>st</sup> Floor  
Los Angeles, California 90057

**DIZZINESS QUESTIONNAIRE**

Name \_\_\_\_\_ Date \_\_\_\_\_

I When you are “dizzy” do you experience any of the following sensations? Please read the entire list first.

Then check **yes** or **no** to describe your feelings most accurately.

- |     |    |  |
|-----|----|--|
| 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: To the right?   |
| Yes | No | To the left?   |
| Yes | No | Forward?   |
| Yes | No | Backward?  |
| Yes | No | 4. Objects spinning or turning around you.   |
| Yes | No | 5. Sensation that you are turning or spinning inside, with outside objects remaining stationary. |
| Yes | No | 6. Sensation of the environment moving up and down while you walk.                               |
| Yes | No | 7. Loss of balance when walking: Veering to the right?   |
| Yes | No | Veering to the left?   |
| Yes | No | 8. Headache.   |
| Yes | No | 9. Nausea or vomiting.   |
| Yes | No | 10. Pressure in the head.  |
| Yes | No | 11. Palpitations, perspiration, shortness of breath, or a feeling of panic.                      |

II Please check **yes** or **no** and fill in the blank spaces. **Answer all questions.**

- |     |    |   |
|-----|----|---|
|     |    | 1. My dizziness is:   |
| Yes | No | Constant?   |
| Yes | No | In attacks?   |
|     |    | 2. When did dizziness first occur? _____                        |
|     |    | 3. If in attacks: How often? _____                              |
|     |    | How long do they last? _____                                    |
|     |    | When was the last attack? _____                                 |
| Yes | No | Do you have any warning that the attack is about to start?      |
| Yes | No | Do they occur at any particular time of day or night?           |
| Yes | No | Are you completely free of dizziness between attacks?           |
| Yes | No | 4. Does change of position make you dizzy?                      |
| Yes | No | 5. Do you have trouble walking in the dark?                     |
| Yes | No | 6. When you are dizzy, must you support yourself when standing? |

**(Please turn page and finish questionnaire.)**

- Yes No 7. Do you know of any possible cause of your dizziness? What? \_\_\_\_\_
8. Do you know of anything that will:
- Yes No Stop your dizziness or make it better? \_\_\_\_\_
- Yes No Make your dizziness worse? \_\_\_\_\_
- Yes No Precipitate an attack? \_\_\_\_\_
- (Fatigue? Exertion? Hunger? Menstrual Period? Stress? Emotional? Upset?)
- Yes No 9. Were you exposed to any irritating fumes, paints, etc., at the onset of dizziness?
- Yes No 10. **If you are allergic** to any medications, please list: \_\_\_\_\_
- \_\_\_\_\_
- Yes No 11. If you ever injured your head, were you unconscious?
- Yes No 12. **If you take any medications** regularly, for any reason, please list: \_\_\_\_\_
- \_\_\_\_\_
- Yes No 13. Do you use tobacco in any form? \_\_\_\_\_ How much? \_\_\_\_\_

III Do you have any of the following symptoms? Please check **yes** or **no** and check **ear** involved.

- |     |    |                          |           |       |      |
|-----|----|--------------------------|-----------|-------|------|
| Yes | No | 1. Difficult in hearing? | Both ears | Right | Left |
| Yes | No | 2. Noise in your ears?   | Both ears | Right | Left |
- 2a. How loud is your tinnitus or head noise most of the time?
- |           |   |
|-----------|---|
| None      | No head noise.  |
| Very Soft | Heard only in a quiet situation.  |
| Moderate  | Heard only in an ordinary situation.  |
| Loud      | Heard and noticed in all situations, even when concentrating on something else. |
- 2b. Describe the noise \_\_\_\_\_
- 2c. Does noise change with dizziness? If so, how? \_\_\_\_\_
- \_\_\_\_\_
- |     |    |   |           |       |      |
|-----|----|---|-----------|-------|------|
| Yes | No | 3. Fullness of stuffiness in your ears? | Both ears | Right | Left |
| Yes | No | 4. Pain in your ears?                   | Both ears | Right | Left |
| Yes | No | 5. Discharge from your ears?            | Both ears | Right | Left |

IV Have you ever experienced any of the following symptoms? Please check **yes** or **no** and check **constant** or in **episodes**.

- |     |    |  |          |             |
|-----|----|--|----------|-------------|
| Yes | No | 1. Double Vision, blurred vision or blindness. | Constant | In Episodes |
| Yes | No | 2. Numbness of face.                           | Constant | In Episodes |
| Yes | No | 3. Numbness of arms or legs.                   | Constant | In Episodes |
| Yes | No | 4. Weakness in arms or legs.                   | Constant | In Episodes |
| Yes | No | 5. Clumsiness of arms or legs.                 | Constant | In Episodes |
| Yes | No | 6. Confusion of loss of consciousness.         | Constant | In Episodes |
| Yes | No | 7. Difficulty with speech.                     | Constant | In Episodes |
| Yes | No | 8. Difficulty with swallowing.                 | Constant | In Episodes |
| Yes | No | 9. Pain in the neck or shoulder.               | Constant | In Episodes |
| Yes | No | 10. Seasickness or car sickness                | Constant | In Episodes |