# L. Richard Shearer, M.D., Inc.
# Dizziness Questionnaire

**Name:** _____ **Date:** _____

**Section I** When you are "dizzy" do you experience any of the following sensations? Please read the entire list first, then circle "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.

3. Tendency to fall:

Yes No 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.

6 Loss of balance when walking.

Yes No Veering to the right?

Yes No Veering to the left?

Yes No 7. Headache.

Yes No 8. Nausea or vomiting.

Yes No 9. Pressure in the head.

**Section II** Please circle "Yes" or "No" and fill in the blank spaces. <u>Answer all questions</u>.

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 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?

Yes No 7. Do you know of any possible cause of your dizziness? If so, what? _____

_____

8. Do you know of anything that will:

Yes No Stop your dizziness or make it better? _____

Yes No Make you 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?

10. If you are allergic to any medications, please list: _____

_____

Yes No 11. If you ever injured your head, were you unconscious?

12. If you take any medications regularly, for any reason, please list: _____

_____

Yes No 13. Do you use tobacco in any form? If so, how much? _____

**Section III** Do you have any of the following symptoms? Please circle "Yes" or "No" and circle ear involved.

Yes No 1. Difficulty in hearing? Both ears Right Left

Yes No 2. Noise in your ears? Both ears Right Left

If so, describe the noise: _____

Does noise change with dizziness? If so, how? _____

_____

Yes No 3. Fullness or 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

**Section IV** Have you experienced any of the following symptoms? Please circle "Yes" or "No" and circle if constant or in episodes.

Yes No 1. Double vision, blurred vision or blindness. Constant Episodes

Yes No 2. Numbness of face. Constant Episodes

Yes No 3. Numbness of arms or legs. Constant Episodes

Yes No 4. Weakness in arms or legs. Constant Episodes

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|---|---|---|---|---|
| Yes | No | 5. Clumsiness of arms or legs. | Constant | Episodes |
| Yes | No | 6. Confusion or loss of consciousness. | Constant | Episodes |
| Yes | No | 7. Difficulty with speech. | Constant | Episodes |
| Yes | No | 8. Difficulty with swallowing. | Constant | Episodes |
| Yes | No | 9. Pain in the neck or shoulder. | Constant | Episodes |