



Dizziness/Imbalance Questionnaire

Patient Name _____ Date _____

Which of these best describes your dizziness? Check only one:

- A sensation of movement of yourself or the room: spinning, tilting or wave-like movement
- Light-headedness or feeling that you are going to faint
- Loss of balance, unsteadiness
- Disorientation with the world, giddiness

When you are “dizzy,” do you experience any of the following sensations?
You may check as many yes responses as necessary:

- Yes No Light-headedness or swimming sensation in the head
- Yes No Blacking out or lack of consciousness
- Yes No Tendency to fall
- Yes No Objects spinning or turning around you
- Yes No Sensation that you are turning or spinning inside
- Yes No Loss of balance when standing or walking
- Yes No Headache
- Yes No Pressure in the head
- Yes No Nausea or vomiting

When did the dizziness first occur? _____

Is the dizziness CONSTANT, or does it come in ATTACKS? _____

If the dizziness comes in attacks, how often do these attacks occur? _____

If the dizziness comes in attacks, how long do these attacks last? _____

What factors provoke the dizziness or make the dizziness worse? _____

What makes the dizziness better? _____

Does your hearing change when the dizziness occurs? Yes No

How? _____

Which ear? Right Left

Are there any other symptoms associated with the dizziness? Check all that apply:

- Blurred vision
- Double vision
- Numbness or tingling in the arms or legs
- Weakness in the arms or legs
- Difficulty speaking
- Difficulty swallowing

Are you completely free of dizziness between attacks? Yes No

Does blowing your nose, coughing or lifting heavy objects make you dizzy? Yes No

Do loud sounds or your own raised voice make you dizzy? Yes No

Have you ever been diagnosed with a head or neck injury? Yes No

If yes, please explain _____

Do you have any history of neurological diseases such as migraine, multiple sclerosis or stroke? Yes No

If yes, please explain _____

Do you have any of the following symptoms? Please check 'Yes' or 'No' and check which ear is involved:

Yes No Difficulty hearing? Right Left

Yes No Noise in your ears (tinnitus)? Right Left

Yes No Fullness or stuffiness in your ears? Right Left

Yes No Does tinnitus change during the dizziness?

If yes, then how? _____