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Hearing and Balance Center

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Dizziness Questionnaire for the Hartford Hospital Balance Clinic

Name: _____ Date: _____

1. Is the dizziness you are experiencing better characterized as a spinning, a light-headedness, or unsteadiness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is the dizziness you are experiencing a continuous symptom or does it come in episodes?	<input type="checkbox"/> Continuous symptom or <input type="checkbox"/> Episodes
3. If it comes in episodes, do the episodes last for: <i>(select one)</i> <input type="checkbox"/> Seconds <input type="checkbox"/> Minutes <input type="checkbox"/> Hours <input type="checkbox"/> Days	
4. When you have episodes, do you experience ringing in the ears, fullness in the ears, or changes in your hearing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Is there nausea or vomiting associated with your dizziness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Is there anything you can do to bring on your dizziness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Does lying down in bed make you dizzy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Does looking up or looking down make you dizzy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Is there anything you can do to improve your dizziness when it is occurring? If yes, what? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Have you ever fallen?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Have you taken medications for dizziness? If so, what? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Does the medication help?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Is your dizziness associated with changes in vision, weakness, or clumsiness in the arms or legs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Do you have a history of migraine headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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