The Hearing and Balance Clinic

Affiliated with Ear, Nose and Throat

Associates of Northern Colorado

DIZZINESS QUESTIONNAIRE

Name: ________________________________ Age:_______ Date: _________________

	YES	NO	**Please describe if YES**
1. How long have you been dizzy?			
2. Is it constant or in attacks?			
3. Is there a symptom free period between attacks?			
4. What brings on the dizziness?			
5. Is the dizziness affected by positional changes?			
6. Do **You** or the **Room** spin when you are dizzy, how long?			
8. Are you lightheaded?			
9. Do you feel you may blackout, do you black out?			
11. Do you have nausea and/or vomiting?			
12. Does any thing relieve the dizziness?			
13. Do you know of any possible cause for your dizziness?			
14. Do you know when an attack is coming and how?			
15. Any previous ear operations?			
16. Do you have ear pressure, does it come and go?			
17. Do your ears ring or buzz, does it come and go?			
18. Do you have any hearing loss, does it come and go?			
19. Does either or both of you ears drain?			
20. Have you ever had any head, neck, whiplash or ear injury?			
21. Were you ever exposed to any irritating fumes, paints, etc. at the onset of dizziness?			
22. Have you taken Drugs or Antibiotics that affected your hearing or balance?			
23. Have you had a cold or the Flu in the last six weeks?			
24. Have you had any slurred or difficult speech?			
25. Have you had double or blurred vision?			
26. Have you had numbness or weakness of the face or			
27. Have you had confusion or loss of consciousness?			
28. Have you had a tendency to fall?			
29. Have you ever smoked, how much?			