Passaic Sleep Medicine
& Neurological Services, PC

Patient Dizziness Questionnaire

Name_____ Date_____

1. 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.
   □ Lightheadedness or feeling that you are going to faint
   □ Loss of balance
   □ Disassociation or disorientation with the world

2. When you are "dizzy" do you experience any of the following sensations? Circle as many yes responses as necessary.

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.
Yes	No	4. Objects spinning or turning around you.
Yes	No	5. Sensation that you are turning or spinning inside.
Yes	No	6. Loss of balance when walking
Yes	No	7. Headache.
Yes	No	8. Pressure in the head.
Yes	No	9. Nausea or vomiting.

3. Please fill in the blanks or circle appropriate answer

   A. When did the dizziness first occur? _____
   B. Is the dizziness CONSTANT or does it come in ATTACKS?
   C. If the dizziness comes in attacks, how often do these attacks occur?
      _____ times per day/ week/ month/ year.

   D. If the dizziness comes in attacks, how long do the attacks last?
      _____ seconds/ minutes/ hours/ days.

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

   F. What makes the dizziness better?
      _____

   G. Does your hearing change when the dizziness occurs?
      Yes/No How? _____
      Which Ear? Right/ Left

H. Are there any other symptoms associated with the dizziness, such as visual changes numbness or tingling in the arms or legs, weakness in the arms or legs, changes in speech?

_____

I. Are you completely free of dizziness between attacks? Yes/ No
J. Have you ever been diagnosed with a head or neck injury? Yes/ No
K. Do you have any history of neurological disease such as migraine, Multiple Sclerosis or stroke?

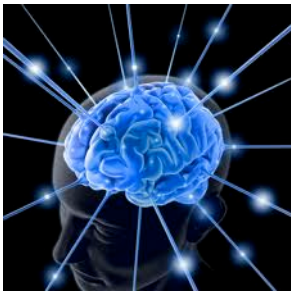
Yes/ No Explain_____

4. Have you experienced any of the following symptoms?

Yes	No	1. Double vision, blurred vision or blindness
Yes	No	2. Numbness of face.
Yes	No	3. Numbness of arms or legs.
Yes	No	4. Weakness in arms of legs.
Yes	No	5. Clumsiness of arms or legs
Yes	No	6. Confusion or loss of consciousness
Yes	No	7. Difficulty with speech.
Yes	No	8. Difficulty with swallowing
Yes	No	9. Pain in the neck or shoulder.

5. Do you have any of the following symptoms? Please circle Yes or No and circle ear involved.

Yes	No	1. Difficulty in hearing?	Right	Left	
Yes	No	2. Noise in ears?	Right	Left	
Yes	No	3. Does noise change during dizziness? How?		Right	Left
Yes	No	4. Fullness or stuffiness in your ears?		Right	Left



1114 Clifton Avenue, Suite 4, Clifton, New Jersey, Tel: 973-928-3288 Fax: 973-928-3286