



## Dizziness and Imbalance Questionnaire

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**When you are dizzy or imbalanced do you experience any of the following sensations? After reading the complete list, check 'Yes' or 'No' for each number to describe your feelings most accurately.**

1. Lightheadedness or swimming sensation in the head  Yes  No
2. Blacking out or loss of consciousness  Yes  No
3. Tendency to fall: 

To the right	<input type="checkbox"/> Yes	<input type="checkbox"/> No
To the left	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Forward	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Backward	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Objects spinning or turning around you  Yes  No
5. Sensation that you are turning or spinning inside, with outside objects remaining stationary  Yes  No
6. Loss of balance when walking: 

Veering to the right	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Veering to the left	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Headache  Yes  No
8. Nausea or vomiting  Yes  No
9. Pressure in the head  Yes  No

**Please check 'Yes' or 'No'. Answer all questions.**

1. My dizziness is: Constant  Yes  No  
In attacks  Yes  No
2. When did dizziness first occur? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
3. If it occurs in attacks:  
How often? \_\_\_\_\_  
How long do they last? \_\_\_\_\_  
When was last attack? \_\_\_\_\_  
Do you have any warning before an attack?  Yes  No  
Do they occur at any particular time of day or night?  Yes  No  
Are you 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, do you need support to stand?  Yes  No
7. Do you know of any possible cause of your dizziness? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. What were you doing when you first noticed the dizziness? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
9. Do you know of anything that will:  
Stop your dizziness or make it better?  Yes  No  
\_\_\_\_\_  
Make your dizziness worse?  Yes  No  
\_\_\_\_\_  
Precipitate an attack? (such as fatigue, exertion, hunger, menstrual  
period, stress, and/or emotional upset)  Yes  No  
\_\_\_\_\_

10. Were you exposed to any irritating fumes, paints, etc., at the onset of dizziness?  Yes  No

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11. If you are allergic to any medications, please list: \_\_\_\_\_

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

13. If you take any medications regularly for any reason, please list: \_\_\_\_\_

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

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

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

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

If so, describe the noise: \_\_\_\_\_

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3. Does noise change with dizziness? If so, how?  Yes  No  
 Both ears  Right ear  Left ear

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4. Fullness or stuffiness in your ears?  Yes  No  
 Both ears  Right ear  Left ear
5. Pain in your ears?  Yes  No  
 Both ears  Right ear  Left ear
6. Discharge from your ears?  Yes  No  
 Both ears  Right ear  Left ear

**Have you experienced any of the following symptoms? Please check 'Yes' or 'No' and whether 'Constant' or in 'Episodes'.**

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

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