

**GW Comprehensive Hearing Center  
Dizziness/Imbalance Questionnaire**

Name: \_\_\_\_\_ MRN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date: \_\_\_\_\_ Reason for visit: \_\_\_\_\_ Referring doctor: \_\_\_\_\_

**1. Which of these best describes your dizziness? Choose 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 specially when you get up too fast
- Loss of balance, unsteadiness
- Disorientation with the world, giddiness

**2. When you are "dizzy" do you experience any of the following sensations? Choose all that apply.**

- |  |            |           |
|--|------------|-----------|
| Change in vision such as seeing spots, blurriness      | <b>Yes</b> | <b>No</b> |
| Change in hearing (If yes, which ear: Right/Left/Both) | <b>Yes</b> | <b>No</b> |
| Blacking out or loss of consciousness                  | <b>Yes</b> | <b>No</b> |
| Pressure build-up in one or both ears                  | <b>Yes</b> | <b>No</b> |
| Ringing in the ear                                     | <b>Yes</b> | <b>No</b> |
| Headache   | <b>Yes</b> | <b>No</b> |
| Numbness, tingling, or weakness in the arms or legs    | <b>Yes</b> | <b>No</b> |
| Difficulty speaking                                    | <b>Yes</b> | <b>No</b> |

**3. Do you have any of the followings? Please circle Yes or No and the ear involved.**

- |                                      |            |           |              |             |
|--------------------------------------|------------|-----------|--------------|-------------|
| Difficulty hearing?                  | <b>Yes</b> | <b>No</b> | <b>Right</b> | <b>Left</b> |
| Noise in your ears (tinnitus)?       | <b>Yes</b> | <b>No</b> | <b>Right</b> | <b>Left</b> |
| Fullness or stuffiness in your ears? | <b>Yes</b> | <b>No</b> | <b>Right</b> | <b>Left</b> |

**4. When did the dizziness first occur?** \_\_\_\_\_

**5. Is the dizziness CONSTANT or does it come in ATTACKS?** \_\_\_\_\_

**6. If it comes in attacks, how often does it occur?** \_\_\_\_\_ times per day / week / month / year

**7. If it comes in attacks, how long does each attack last?** \_\_\_\_\_ seconds/minutes/hours/days

**8. What factors provoke the dizziness or make the dizziness worse?**

- |   |            |           |
|---|------------|-----------|
| Change in head or body position                                 | <b>Yes</b> | <b>No</b> |
| Rapidly moving object such as metro, computer screen            | <b>Yes</b> | <b>No</b> |
| Food and dietary triggers such as caffeine, salt, wine, etc     | <b>Yes</b> | <b>No</b> |
| Loud noise  | <b>Yes</b> | <b>No</b> |
| Straining such as blowing nose, coughing, lifting heavy objects | <b>Yes</b> | <b>No</b> |

**9. What makes the dizziness better?** \_\_\_\_\_

**10. Are you completely free of dizziness between attacks?** **Yes** **No**

**11. Do you have any history of a neurological disease such as migraine, multiple sclerosis, stroke, or head trauma?** Yes / No If so, explain: \_\_\_\_\_