

Try to describe your dizziness by selection any of the following that seem to apply:

- primarily light-headedness
- primarily unsteadiness
- sensation of spinning
- floating sensation
- drifting or rocking sensation as if in a boat
- buzzy, strange sensation in the head, but no feeling of motion outside the head
- spinning feeling inside the head but no actual sensation of motion
- feeling of impending loss of consciousness
- difficulty controlling the body
- clumsy sensation
- other

How bad is your dizziness?

- No effect on daily activities
- Very mild, has no effect on daily activities
- Mild, have to stop when dizzy, but otherwise has no effect on daily activities
- Moderate, interfering with daily activities a little
- Severe, must constantly make adjustments to daily activities
- Very severe, cannot engage in normal activities. Even essential activities are limited, I am disabled.
- Extremely severe, have been disabled for one year or longer by the dizziness

Are you experiencing the dizziness now?  Yes  No

How long have you had the dizziness? \_\_\_\_\_

Setting in which problem first occurred:

- |  |   |
|--|---|
| <input type="checkbox"/> After a "cold" or "flu" infection | <input type="checkbox"/> After head injury  |
| <input type="checkbox"/> After a CVA                       | <input type="checkbox"/> Getting out of bed |
| <input type="checkbox"/> After exposure to an explosion    | <input type="checkbox"/> Other: _____       |
| <input type="checkbox"/> After exposure to very loud noise | <input type="checkbox"/> None               |

Do any of the following factors cause your dizziness or make it worse?

- |  |   |
|--|---|
| <input type="checkbox"/> Exercising                    | <input type="checkbox"/> Sneezing or coughing               |
| <input type="checkbox"/> Looking up or up and backward | <input type="checkbox"/> Using the arms quickly or forcibly |
| <input type="checkbox"/> Exposure to loud noise        | <input type="checkbox"/> When walking                       |
| <input type="checkbox"/> Rapid changes in position     | <input type="checkbox"/> None                               |
| <input type="checkbox"/> Rapid eye motion              | <input type="checkbox"/> Other: _____                       |
| <input type="checkbox"/> Rotating the head             |   |

Select any of the problems that seem to be associated with the dizziness:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Fullness in the ear                   | <input type="checkbox"/> Sensation of smothering or shortness of breath       | <input type="checkbox"/> Awareness of the heart beating hard |
| <input type="checkbox"/> Ear noise                             | <input type="checkbox"/> Loss of consciousness during dizzy attack            | <input type="checkbox"/> Nervous shaky sensation             |
| <input type="checkbox"/> Hearing loss                          | <input type="checkbox"/> Tingling sensation in fingers                        | <input type="checkbox"/> Seizures associated with dizziness  |
| <input type="checkbox"/> Ear pain                              | <input type="checkbox"/> Recurrent headache but not associated with dizziness | <input type="checkbox"/> Double vision                       |
| <input type="checkbox"/> Otorrhea                              | <input type="checkbox"/> Headache usually occurring after dizziness           | <input type="checkbox"/> Difficulty in speech                |
| <input type="checkbox"/> Previous ear surgery                  | <input type="checkbox"/> Acute headache that began with dizziness             | <input type="checkbox"/> Difficulty swallowing               |
| <input type="checkbox"/> Nausea without vomiting               |   | <input type="checkbox"/> Other: _____                        |
| <input type="checkbox"/> Nausea and vomiting                   |   | <input type="checkbox"/> None                                |
| <input type="checkbox"/> Sweating                              |   |  |
| <input type="checkbox"/> Falls with injury caused by dizziness |   |  |

List any previous tests you have had: \_\_\_\_\_

List any previous treatments you have had: (home remedies, physical or occupational therapies, acupressure or acupuncture therapies, massage therapy, chiropractic therapy, etc) and their effectiveness: \_\_\_\_\_

List any medications you have tried and their effectiveness: \_\_\_\_\_