

**MEMORIAL NEUROLOGICAL ASSOCIATION**

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**DIZZINESS AND VERTIGO QUESTIONNAIRE**

**PLEASE CIRCLE**

When you are dizzy or have vertigo do you perceive:    Movement    Light Headedness    Unsteadiness

Do you have:

- |                             |                     |                            |                                |
|-----------------------------|---------------------|----------------------------|--------------------------------|
| Ear Pain                    | Headache            | Speech Difficulties        | Double Vision                  |
| Blurred Vision              | Nausea              | Cold or Flu Symptoms       | Vision Problems                |
| Confusion                   | Ringing in the Ears | Allergies                  | Shortness of Breath            |
| Decreased Hearing           | Vomiting            | Chest Pain or Pressure     | Numbness Around the Mouth      |
| Popping or Pressure in ears | Body Numbness       | Palpitations               | Pain in your Neck or Shoulders |
| Sweating                    | Weakness            | Fainting Spell or Pass Out | Head Injury                    |

I get dizzy when I:

- |                  |                                   |                  |
|------------------|-----------------------------------|------------------|
| Bend Over        | Rise from a Chair                 | Pressure Changes |
| Stoop            | Stand Up                          | Seasonal Changes |
| Turn in Bed      | Move my Head in certain positions | Menses           |
| Walk             | Eat                               | Other _____      |
| Make Quick Turns | Visual Stimuli s                  |                  |

The following factors worsen my symptoms:

- |           |                     |
|-----------|---------------------|
| Coughing  | Riding in a Vehicle |
| Straining | Loud Noises         |
| Sneezing  | Other _____         |
| Driving   |                     |

How long have you had your symptoms \_\_\_\_\_

The following improve my symptoms \_\_\_\_\_

Past Treatments: Meclizine or Antivert    Ear Patch    Other \_\_\_\_\_

Past Tests: MRI    MRA    EEG    ENG    CT SCAN    SINUS EVALUATION    AUDIOGRAM    BLOOD TEST

The severity of my symptoms are – Annoying    Mild    Moderate    Severe    Disabling

How frequent are your dizzy symptoms \_\_\_\_\_

How long do your dizzy symptoms last – Seconds    Less than a Minute    Minute to an Hour    Hours to Days  
Days to Weeks    Month to Years

How does the ringing in your ears sound – High Pitched    Low Pitched    Roaring Sound (sea shell)    Musical

PATIENT NAME \_\_\_\_\_ ACCT # \_\_\_\_\_ DATE \_\_\_\_\_