

MEMORIAL NEUROLOGICAL ASSOCIATION

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Electromyography
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DIZZINESS AND VERTIGO QUESTIONNAIRE

PLEASE CIRCLE

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

How long have you experienced these symptoms _____

Do you have:

Ear pain	Blurred vision	Nausea	Shortness of breath
Decreased hearing	Double vision	Vomiting	Numbness around mouth
Popping or pressure in ears	Confusion	Generalized Fatigue	Anxiety
Cold or flu symptoms	Speech difficulties	Fainting spells or passing out	Pain in neck or shoulders
Allergies	Weakness	Palpitations	Head injury
Headache	Numbness of the body	Chest pain or pressure	

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

I get dizzy when I:

Bend Over	Make quick turns	Seasonal changes
Stoop	Rise from a chair	Menses
Turn in Bed	Eat	Other _____

The following factors worsen my symptoms:

Coughing	Loud noises
Straining	Other _____
Rising in a vehicle	

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 does one dizzy attack last – Seconds Less than a Minute Minute to an Hour Hours to Days
Days to Weeks Month to Years

PATIENT NAME _____ ACCT # _____ DATE _____