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PRETORIA DIZZINESS AND VERTIGO CLINIC

QUESTIONNAIRE

Name: | Age: | Gender: | Date:

- The following questions refer to your feeling of dizziness or imbalance.
- Tick “yes” or “no” in allocated blocks and complete all questions
- Please take your time and be as specific as possible
- Bring the questionnaire with you during your first visit to the dizziness clinic
- Your care will be more efficient if you provide us with pertinent test results, such as CT of the head and neck, MRI of the head and neck, hearing tests including all audiograms (hearing tests), and tests of balance function such as VNG, VEMP tests.

A. MAIN COMPLAINT

Please describe in your own words, the main reason why you are visiting our dizziness clinic today? Explain in the sensation you feel, without using the word “dizzy”.

Which one of the following sensations describes your dizziness the best?

	YES	NO
Your head is spinning in circles or the world is spinning around you?	☐	☐
Light-headedness, a feeling like when you want to faint or having a blackout?	☐	☐
Do you feel off balance or a feeling of falling?	☐	☐

Please explain:

B. YOUR FIRST DIZZINESS EPISODE

Briefly describe your first ever dizziness attack:

What was the date of your first ever dizziness attack?

How long did your first dizziness attack last?

- seconds (less than 60 seconds) ☐
- minutes (less than 60 minutes) ☐
- hours (less than 24 hours) ☐

How did your dizziness start?

- Was it a sudden attack or ☐
- Did it start gradually? ☐

C. THE FOLLOWING ARE RELATED TO YOUR DIZZINESS AFTER THE FIRST EPISODE

	YES	NO
You do not experience any dizziness after the first attack?	☐	☐
You are experiencing a permanent imbalance?	☐	☐
You do get recurrent dizziness attacks?	☐	☐
You are still getting spinning dizziness and is part of your current attack?	☐	☐
You are permanently dizzy?	☐	☐

If your dizziness occurs in attacks, how long does it last?

- less than 60 seconds? ☐
- 5 minutes to 72 hours? ☐
- 20 minutes to 12 hours? ☐

How frequent are the attacks:

- daily? ☐
- weekly? ☐
- monthly? ☐
- yearly ☐

	YES	NO
Are you free from dizziness between the attacks?	☐	☐

D. ACCOMPANYING SYMPTOMS

Do you have any warning symptoms before a dizziness attack? **Yes** ☐ **No** ☐

Please explain:

	YES	NO
Does your hearing change during an attack?	☐	☐
Have you had a fullness or pressure feeling in your ears during the attack?	☐	☐
Have you had tinnitus or any noise in your ears during the attack?	☐	☐
Do you have any sensitivity to light or sound during an attack?	☐	☐
Are you nauseous during an attack?	☐	☐
Are you vomiting during an attack?	☐	☐
Do you have any headaches during an attack?	☐	☐
Do you black out or faint during the attack?	☐	☐
Do you have any numbness in your face/ extremities or tingling around your mouth?	☐	☐
Do you have any double vision during an attack?	☐	☐
Do you have any weakness in your arms or legs during an attack?	☐	☐
Do you suffer from seasickness or motion sickness?	☐	☐
Please explain:		
Do you have a tendency of feeling unsteady or falling to the left, right, forward or backward when walking?	☐	☐
Please explain:		

E. AGGRAVATING / PRECIPITATING FACTORS

Are your dizziness, vertigo or imbalance affected by (don't mark if not applicable or don't know):

	Worsens	No effect	Improves
Lying down in bed or turning over in the bed to the left or right?	☐	☐	☐
Do you experience any dizziness when looking up or bending down?	☐	☐	☐
Standing up from sitting	☐	☐	☐
Rapid head movements	☐	☐	☐
Walking in a dark room	☐	☐	☐
Motion such as air-plane, boat or car travel	☐	☐	☐
Loud noises	☐	☐	☐
Bright lights	☐	☐	☐
Coughing, blowing the nose, or straining	☐	☐	☐
Grocery stores, narrow or wide open visual spaces	☐	☐	☐
Exercise	☐	☐	☐
Stress	☐	☐	☐
Alcoholic beverages	☐	☐	☐
Menstrual periods	☐	☐	☐

F. EAR SYMPTOMS

	YES	NO	Left	Right
Pain in ears?	☐	☐	☐	☐
Tinnitus (sound) in your ear?	☐	☐	☐	☐
Discharge from ears?	☐	☐	☐	☐
Exposure to loud noises?	☐	☐	☐	☐
Family history of deafness?	☐	☐	☐	☐
Previous ear infections?	☐	☐	☐	☐
Previous ear surgery?	☐	☐	☐	☐

Please provide details:

G. HABITS AND LIFESTYLE

	YES	NO
Did you recently change eyeglasses?	☐	☐
Have you ever had weakness or faintness a few hours after eating?	☐	☐
Do you drink tea or coffee? How much:	☐	☐
Do you drink soft drinks? How much:	☐	☐
Do you drink alcohol? How much:	☐	☐
Do you smoke? What: How much:	☐	☐

Do you know what is the cause of your dizziness? Please explain:

H. PAST MEDICAL HISTORY

H.1 Please list your current medical problems and length of illness:

H.2 Please list all surgery performed and approximate dates:

H.3 Please list all allergies (including drugs) and reaction:

H.4 Please list all medicines you currently take (including pain medicine, non-prescription medicine, nerve pills, sleeping pill, or birth control pills):

H.5 Have you had any previous testing (hearing, x-rays, head scans, etc.)?:

H.6 Please list any diseases that run in your immediate family:

H.7 Any family history of:

	YES	NO
Migraine?	☐	☐
High blood pressure?	☐	☐
Low blood pressure?	☐	☐
Diabetes?	☐	☐
Low blood sugar?	☐	☐
Thyroid disease?	☐	☐
Asthma?	☐	☐

H.8 Do you have anything else to tell us about your particular problem that we have not asked you on this questionnaire?

J. DIZZINESS HANDICAP INVENTORY

		Yes	Sometimes	No
1.	Does looking up increase your problem?	☐	☐	☐
2.	Because of your problem, do you feel frustrated?	☐	☐	☐
3.	Because of your problem, do you restrict your travel for business or recreation?	☐	☐	☐
4.	Does walking down the aisle of a supermarket increase your problem?	☐	☐	☐
5.	Because of your problem, do you have difficulty getting into or out of bed?	☐	☐	☐
6.	Does your problem significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing, or to parties?	☐	☐	☐
7.	Because of your problem, do you have difficulty reading?	☐	☐	☐
8.	Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem?	☐	☐	☐
9.	Because of your problem, are you afraid to leave your home without having some one accompany you?	☐	☐	☐
10.	Because of your problem, have you been embarrassed in front of others?	☐	☐	☐
11.	Do quick movements of your head increase your problem?	☐	☐	☐
12.	Because of your problem, do you avoid heights?	☐	☐	☐
13.	Does turning over in bed increase your problem?	☐	☐	☐
14.	Because of your problem, is it difficult for you to do strenuous housework or yard work?	☐	☐	☐
15.	Because of your problem, are you afraid people may think you are intoxicated?	☐	☐	☐
16.	Because of your problem, is it difficult for you to walk by yourself?	☐	☐	☐
17.	Does walking down a side walk increase your problem?	☐	☐	☐
18.	Because of your problem, is it difficult for you to concentrate?	☐	☐	☐
19.	Because of your problem, is it difficult for you to walk around your house in the dark?	☐	☐	☐
20.	Because of your problem, are you afraid to stay home alone?	☐	☐	☐
21.	Because of your problem, do you feel handicapped?	☐	☐	☐
22.	Has your problem placed stress on your relationships with members of your family or friends?	☐	☐	☐
23.	Because of your problem, are you depressed?	☐	☐	☐
24.	Does your problem interfere with your job or household responsibilities?	☐	☐	☐
25.	Does bending over increase your problem?	☐	☐	☐