Dizziness Complaint Medical Questionnaire

office@paulmontgomery.co.uk

Name: **D.O.B.**

Address: **Email:**

Mobile:

Date of completion of Questionnaire:

Please describe in your own words, the sensation you feel without using the word "dizzy" or "vertigo"

Specific Questions (Please Circle your response)

Which groups that best describes your "dizziness"

Group A) **I experience a sensation in my head of** "spinning" - "whirling" – "like getting off a merry-go-round"- "the ground tilts up and down" - "like being on a boat at sea."

Group B) **When you are moving about:** "Unsteady on walking"- "unsteady on feet" -"off-balance"-" Like stepping of a boat" – "when I walk it's like being drunk"

Group C) **When you are not moving about: "**I am just Dizzy*"*-*"*Spaced out" – "Floating" – "Rocking" – "Swaying"- "Like my head is not attached to my body" – "Lightheaded"

Group D) **I experience a sensation in my head that** *"*I might faint*"*-"I am about to pass out"- "A Fainting feeling"-"I have Fainted"

How long have you had this dizziness problem for (Please circle)?
1 week, 2 weeks, 3 weeks, 1 month, 2 months, 3 months or more, Years

Is this your first attack of Dizziness
First Single Attack – Yes/No

Do you get

Recurring Attacks of Dizziness – Yes/No

OR

Are you Dizzy all the time? – Yes/No

How Many Attacks of Dizziness have you had?

How frequent are they?
? Once a day,? once a week etc

How long does an Individual Dizzy attack last (this does not including the time you feel unwell after the dizzy attack)?

Did anything start off this whole dizziness problem?

Are there specific triggers a Dizzy attack such as:-

Turning over in bed – Yes/No

Bending over to tying laces – Yes/No

Looking up/Reaching up to a shelf – Yes/No

Wearing a collar or tie, shaving - Yes/No

Going to the bathroom at night in the dark – Yes/No

Bearing down when going to the bathroom – Yes/No

Wearing a collar or tie, shaving – Yes/No

Going downstairs – Yes/No

Getting up from a chair quickly – Yes/No

Coughing/Sneezing – Yes/No

Doors Slamming – Yes/No

Specific Visual stimulus – Yes/No – if yes please circle areas of difficulty

Being on bridges,
Driving a car,
Empty rooms,
Long corridors,
Going down a supermarket aisle
Busy high streets,
Cinema,
Televisions
Computers,
Neon lights

Specific Foods – Yes/No – if yes please circle areas which one
e.g. Salty Food, dark chocolate, Cheese

<u>During a Dizzy attack do you get?</u>

Ear Problems – Yes/No

Specifically: -

Hearing Loss – Yes/No Right Ear/Left Ear /Both Ears

Buzzing sound in Your Ear – Yes/No Right Ear/Left Ear /Both Ears

Fullness feeling in your Ear –Yes/No Right Ear/Left Ear /Both Ears

Discharge from your Ear – Yes/No Right Ear/Left Ear /Both Ears

Earache/Pain – Yes/No Right Ear/Left Ear /Both Ears

Visual Problems – Yes/No

Specifically: -

Light is Irritating – Yes/No

Double Vision – Yes/No

Bad Headache Problems – Yes/No

Specifically:-

Do you get spots before your eyes

You find Sound irritating – Yes/No

Falls & Blackouts & Faints – Yes/No

Other Specific Problems

Staggering – Yes/No
Poor memory– Yes/No
Urinary/water works problems – Yes/No
Fits/seizures – Yes/No
Twitching – Yes/No
Shaking hands when picking things up – Yes/No
Difficulty writing – Yes/No
Difficulty speaking – Yes/No
Difficulty swallowing – Yes/No
Numbness/tingling of face, arms & legs – Yes/No
Numbness for mins – Yes/No
Numbness for hours – Yes/No
Numbness all the time – Yes/No
Cannot feel the ground underneath your feet normally – Yes/No
Nausea – Yes/No
Sweating – Yes/No

<u>What is the impact of the Dizziness problem on your life?</u>
Difficulty reading mobile phone in the back of a car or taxi – Yes/No
Difficulty going down stairs – Yes/No
Cannot go out – Yes/No
Cannot drive – Yes/No
Cannot work – Yes/No
Poor motivation – Yes/No
Poor Concentration – Yes/No
Low mood, poor sleep & anxiety – Yes/No
Unsteady walking to the bathroom at night in the dark – Yes/No
"Foggy" or "Cotton Wool" Head – Yes/No
Chronic Fatigue – Yes/No

<u>How is the dizziness progressing?</u>
No change
Improving
Worsening
Up and Down

Previous Ear disease – Yes/No
Please describe:

Major Noise exposure – Yes/No
Please describe:

Medical Conditions e.g Migraine/Head Injury– Yes/No
Please describe

Family History of Medical Conditions e.g Migraine– Yes/No
Please describe

Have you had new Glasses fitted – Yes/No

Your Medicines– Yes/No
Please describe:

Your Allergies– Yes/No
Please describe: