Vertigo/Dizziness/Imbalance Complaint Medical Questionnaire

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

Address:

Email:

Mobile:

GP Name & Address:

GP Email:

Date of completion of Questionnaire:

Please tell me what has happened to you:-

Specifically, could you describe the "dizzy" or "vertigo" or "imbalance" sensation you feel using other phrases or words e.g. "spinning" or "being on a boat" etc

Please could you describe a typical dizzy/vertigo/imbalance attack : how it would begin, what you would experience etc

Specific Questions (Please Circle/Highlight your response)

Which group(s) 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"

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

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

Are they mainly before breakfast? – Yes/No

How long does an Individual Dizzy attack last (this does not including the time you feel unwell after the dizzy attack)? - Please highlight/circle
Seconds
Minutes
Hours
Days
Weeks
All the time

Did anything start off this whole dizziness problem?
For example: -

Ear Problems – Yes/No

Serious medical illness – Yes/No

Psychological stress – Yes/No

Are there specific **TRIGGERS** of 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

Bearing down when on the toilet – Yes/No

Getting up from a chair quickly – Yes/No

Coughing/Sneezing/blowing your nose – Yes/No

Do loud sounds, such as doors slamming, make you have a dizziness/vertigo/imbalance attack – Yes/No

Specific Visual triggers

Being on bridges – Yes/No
Driving a car – Yes/No
Empty rooms – Yes/No
Long corridors – Yes/No
Going down a supermarket aisle – Yes/No
Busy high streets – Yes/No
Cinema – Yes/No
Televisions – Yes/No
Computers – Yes/No
Neon lights – Yes/No

Raining/bad weather– Yes/No

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

JUST BEFORE or DURING a "DIZZY" ATTACK - Do you get?

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
Sound irritating – Yes/No	Right Ear/Left Ear /Both Ears

Visual Problems – Yes/No

Specifically: -
Sensitive or irritation with light – Yes/No
Flashing lights/zigzags/ kaleidoscope of colours, blurry, blind, dark spots before your eyes – Yes/No

Bad Headaches – Yes/No

Specifically: -
Are your headaches clearly associated with dizziness/imbalance – Yes/No
Are your headaches worse with lifting heavy objects – Yes/No

Falls & Blackouts & Faints – Yes/No

Palpitations – Yes/No

Other Specific Problems

Staggering – Yes/No
It disappears quickly - Yes/No
It lasts for many days/weeks- - Yes/No

Difficulty speaking/Slurred Speech – Yes/No
It disappears quickly - Yes/No
It lasts for many days/weeks - Yes/No

Difficulty swallowing – Yes/No
It disappears quickly - Yes/No
It lasts for many days/weeks- - Yes/No

Numbness/tingling of face – Yes/No
It disappears quickly - Yes/No
It lasts for many days/weeks - Yes/No

Numbness/tingling of arms – Yes/No
It disappears quickly - Yes/No
It lasts for many days/weeks - Yes/No

Numbness/tingling of legs – Yes/No
It disappears quickly - Yes/No
It lasts for many days/weeks - Yes/No

Cannot feel the ground underneath your feet normally – Yes/No
It disappears quickly - Yes/No
It lasts for many days/weeks - Yes/No

Have you started to drop things – Yes/No

Have you started to have falls – Yes/No

Do you hear the sound of your breathing in one or both ears when you sit and read – Yes/No

Fits/seizures – Yes/No

Poor memory– Yes/No

What is the impact of the Dizziness problem on your life?

Difficulty reading mobile phone in the back of a car or taxi – 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

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

Motion sickness/sea sickness as child or adult – Yes/No
Please describe:

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:

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