Fraser Health
Acute Audiology Services
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Dizziness (Vestibular) Questionnaire

Patient's Name: _____ **Date:** _____

Date of Birth: _____**Occupation:** _____

Please spend a few minutes answering the questions regarding your history and symptoms. Answer the questions to the best of your ability and be assured how you answer will not affect your evaluation.

When did your dizziness first occur? What were you doing when it came on?
Please describe initial onset.

Was it associated with a related event (e.g., head injury?) ☐ Yes ☐ No
Onset of your symptom: ☐ Sudden ☐ Gradual ☐ Overnight ☐ Other

Did you experience any of the following sensations when it first occurred?
Please read the entire list first, then check the box(es) that best describe your symptoms.

☐ Light-headedness, faintness, floating or rocking sensation
☐ Objects moving, spinning or turning around you
☐ Sensation that you are turning or spinning inside, while outside objects are stationary
☐ Sensation of falling to one side, being heavily weighted or pulled/pushed in one direction
☐ Imbalance, unsteadiness
☐ Swimming sensation (as if the world takes a moment to catch up) with head turns
☐ Disorientation
☐ Blacking out (vision)
☐ Loss of consciousness

How long did your first episode last? *(Please check the appropriate box.)*
☐ Seconds ☐ Minutes ☐ Hours ☐ Day(s) ☐ Weeks ☐ Has remained constant

Are there any other symptoms that came along with that first dizziness?
Please read the entire list first, then check the box(es) to describe your symptoms.

☐ Nausea
☐ Loss of Balance
☐ Double vision
☐ Slurred speech/difficulty speaking
☐ Falls
☐ Decreased hearing in one or both ears
☐ Feeling of pressure in one or both ears
☐ Vomiting
☐ Headache
☐ Blindness/vision blacking out
☐ Limb incoordination
☐ Pressure in your head
☐ Tinnitus (sounds) in one or both ears

What relieves your symptoms? _____

Do sneezing, coughing, holding your breath or specific sounds trigger your dizziness or make it worse? ☐ Yes ☐ No

Is there an associated sensitivity to lights, sounds or odours with your dizziness? ☐ Yes ☐ No

Is your dizziness recurrent? ☐ Yes ☐ No

If yes, how often does the dizziness occur? _____

How long does an episode of dizziness typically last? _____

Are you ever completely free of dizziness/imbalance? ☐ Yes ☐ No

Do you have any warning signs prior to the dizziness episodes? ☐ Yes ☐ No

Is there anything you can do to trigger the dizziness? ☐ Yes ☐ No

Is your dizziness brought on by positional changes or non-specific head movement? ☐ Yes ☐ No

Are your episodes triggered and/or worsened with… **(***Please check the box(es) that apply.)*

☐ Lying down in bed
☐ Sitting up in bed
☐ Rolling over in bed to the R / L
☐ Looking from side to side
☐ Standing up quickly
☐ Bending forward
☐ Pitching head backward
☐ Stress
☐ Certain food or drink choices

Are your dizziness symptoms
☐ improving? ☐ getting worse? ☐ staying the same?

Have you undergone any treatment for the dizziness?
☐ medication? ☐ vestibular therapy? ☐ physiotherapy? ☐ chiropractic therapy ?
☐ other? _____

Have you undergone any tests?
☐ MRI ☐ CT Scan ☐ Other _____

Please check any of the following that apply to you.
☐ Consume alcohol ☐ Smoke ☐ Use recreational drugs

Have you been experiencing any of the following?
Please check the box(es) that best describe your experience.

☐ Double vision
☐ Blindness
☐ Blurred vision
☐ Spots before your eyes
☐ Confusion
☐ Anxiety
☐ Pressure in your head
☐ Fear of falling
☐ Nausea or vomiting
☐ Unexplained weight loss/gain
☐ Numbness/tingling
☐ Slurred speech
☐ Tingling around the mouth
☐ Unexplained weakness/loss of strength
☐ Poor coordination
☐ ”Drunk” feeling when walking
☐ Difficulty in swallowing
☐ Abnormal fatigue
☐ Passed out or lost consciousness
☐ Difficulty walking in the dark/ on uneven surfaces
☐ Problems turning to the ☐ Right ☐ Left
☐ Tendency to fall to the ☐ Right ☐ Left ☐ Forward ☐ Backward
☐ When walking, you ☐ veer right ☐ veer left ☐ remain in a straight path

Do/Did you experience any of the following sensations?
Please check the box(es) that describe your feelings most accurately.

☐ Motion sickness <u>as a child</u>
☐ Motion sickness, airsickness or seasickness <u>as an adult</u>
☐ Family history of motion sickness
☐ History of migraine headaches
☐ Exposure to the solvents *Toluene, Styrene,* or *Carbon Disulfide*
If yes, when? _____ and for how long?_____
☐ Head injuries. When? _____ Did you lose consciousness? ☐ Yes ☐ No
☐ Neck injury. When? _____

Have you ever had any of the following? *Please check appropriate box.*

☐ Intravenous antibiotics
☐ Radiation therapy
☐ Chemotherapy
☐ Ear surgery
☐ Syphilis
☐ Cold sores (herpes virus)
☐ Noise exposure
☐ Shingles (related to Chicken Pox virus)

Do you have difficulty hearing? ☐ Yes ☐ No
If yes, is it in ☐ Both ears ☐ Right ear ☐ Left ear
Since when? _____
Is your hearing getting worse? ☐ Yes ☐ No
Does your hearing ever seem better? ☐ Yes ☐ No

Do you have noises in your ears/head? ☐ Yes ☐ No
If yes, is it in ☐ Both ears ☐ Right ear ☐ Left ear ☐ Head
Since when? _____
Is the sound getting worse? ☐ Yes ☐ No
Does the sound go away? ☐ Yes ☐ No

Do you have fullness/stuffiness in your ears? ☐ Yes ☐ No
If yes, is it in ☐ Both ears ☐ Right ear ☐ Left ear
Since when? _____
Does the fullness go away? ☐ Yes ☐ No

Do you have pain in your ears? ☐ Yes ☐ No
If yes, is it in ☐ Both ears ☐ Right ear ☐ Left ear
Since when? _____
Does the pain go away? ☐ Yes ☐ No

Do you have discharge from your ears? ☐ Yes ☐ No
If yes, is it in ☐ Both ears ☐ Right ear ☐ Left ear

Do you have (or have you had) any of the following medical problems?
Please check the box(es) that apply.

☐ Diabetes
☐ Strokes
☐ Hypertension
☐ Coronary artery disease
☐ Osteoporosis
☐ Visual difficulty
☐ Seizures
☐ Aneurysms
☐ Neuromuscular disorders (e.g., MS, Parkinson's, MD)
☐ Psychiatric condition _____

What medications are you taking currently?
Please provide a list, what they are for, and the approximate length of time you have been taking them

NAME OF MEDICATION	USED FOR?	USED FOR HOW LONG?

*Please refer to the **Pre-Test Instructions** pamphlet regarding which medications to abstain from for 48 hours prior to testing. If you have concerns whether or not to take a particular medication, please consult with your referring physician to determine if you can safely stop the medication for the 48 hours or if you can use an alternative medication that is not restricted.* ***You should always consult with your physician before discontinuing any prescribed medication.***

Dizziness Handicap Inventory

The purpose of this questionnaire is to identify difficulties you may be experiencing because of your dizziness or unsteadiness. Please answer each question as it pertains to your dizziness problem only, by marking *"**yes**," "**sometimes**," or "**no**" (with a check mark)* to best describe your experience.

1. Does looking up increase the dizziness? (P) ☐Yes ☐Sometimes ☐No
2. Because of the dizziness, do you feel frustrated? (E) ☐Yes ☐Sometimes ☐No
3. Because of the dizziness, do you restrict your travel for business or recreation? (F) ☐Yes ☐Sometimes ☐No
4. Does walking down the aisle of a supermarket increase the dizziness? (P) ☐Yes ☐Sometimes ☐No
5. Because of the dizziness, do you have difficulty getting into or out of bed? (F) ☐Yes ☐Sometimes ☐No
6. Does the dizziness significantly restrict your participation in social activities such as going out to dinner, the movies, or to parties? (F) ☐Yes ☐Sometimes ☐No
7. Because of the dizziness, do you having difficulty reading? (F) ☐Yes ☐Sometimes ☐No
8. Does performing more ambitious activities like sports, dancing, household chores increase the dizziness? (P) ☐Yes ☐Sometimes ☐No
9. Because of the dizziness, are you afraid to leave your home without having someone accompany you? (E) ☐Yes ☐Sometimes ☐No
10. Because of the dizziness, have you felt embarrassed in front of others? (E) ☐Yes ☐Sometimes ☐No
11. Do quick movements of your head increase the dizziness? (E) ☐Yes ☐Sometimes ☐No
12. Because of the dizziness, do you avoid heights? (F) ☐Yes ☐Sometimes ☐No
13. Does turning over in bed increase the dizziness? (P) ☐Yes ☐Sometimes ☐No
14. Because of the dizziness, is it difficult for you to do strenuous housework or yard work? (F) ☐Yes ☐Sometimes ☐No
15. Because of the dizziness, are you afraid people may think you are intoxicated? (F) ☐Yes ☐Sometimes ☐No
16. Because of the dizziness, is it difficult for you to go for a walk by yourself? (F) ☐Yes ☐Sometimes ☐No
17. Does walking down a sidewalk increase the dizziness? (P) ☐Yes ☐Sometimes ☐No
18. Because of the dizziness, is it difficult for you to concentrate? (E) ☐Yes ☐Sometimes ☐No
19. Because of the dizziness, is it difficult for you to walk around your house in the dark? (F) ☐Yes ☐Sometimes ☐No

20. Because of the dizziness, are you afraid to stay home alone? (E) ☐Yes ☐Sometimes ☐No
21. Because of the dizziness, do you feel handicapped? (E) ☐Yes ☐Sometimes ☐No
22. Has the dizziness placed stress on your relationships with members of your family and friends? (E) ☐Yes ☐Sometimes ☐No
23. Because of the dizziness, are you depressed? (E) ☐Yes ☐Sometimes ☐No
24. Does the dizziness interfere with your job or household responsibilities? (F) ☐Yes ☐Sometimes ☐No
25. Does bending over increase the dizziness? (P) ☐Yes ☐Sometimes ☐No

Reference: Jacobson, GP, Newman, CW. *The development of the Dizziness Handicap Inventory*. Arch Otolaryngol Head Neck Surg. 1990 Apr; 116(4): 424-7.

Thank you.