Dizziness Questionnaire

1. **My dizziness can be best described as:**

_____

_____

2. **When did your dizziness first start?**

_____

_____

3. **How long does your dizziness last when you have an episode?**
   Days Hours Minutes Seconds

4. **How often do your episodes occur?**
   Daily Weekly Occasionally

5. **When does your dizziness occur?**

_____

_____

6. **Has your dizziness improved since it started?**

_____

_____

7. **Are you having any other ear related symptoms? YES or NO**
   If yes: Ringing/Buzzing Fullness Hearing Loss Pain
   Other:_____

_____

8. **Do you have any issues limiting your mobility? YES or NO**
   If yes: Neck Pain Back Pain Wheelchair Cane/Walker
   Other:_____

_____

9. **Do you have any vision problems? YES or NO**
   If yes: Glasses Contacts Cataracts Glaucoma
   Other:_____

_____

10. **Additional Comments:**

_____

_____

_____