



Vestibular Questionnaire

Name: _____ MR#: _____ Date: _____

Address: _____ Phone #: _____

I. When you are dizzy, do you experience any of the following sensations? Circle the terms that describe your feelings most accurately.

- | | |
|----------------------|---|
| Light headedness | Sensation that you are turning |
| Headache | Sensation that things are turning around you |
| Nausea or vomiting | Dizziness occurs in attacks |
| Pressure in the head | Dysequilibrium – sensation of falling to one side |
| Spinning | Other (please specify): _____ |

II. Please *fill in* the blank spaces:

1. Is your dizziness constant? _____
2. Does it come in attacks? _____
3. How often do the attacks occur? _____
4. How long are the attacks? _____
5. When did the dizziness first occur? _____ Are you getting better? _____
6. Does the dizziness occur only in certain positions? _____
 When upright? _____
 When lying flat? _____
 Turning to the right/left? _____
7. Have you ever stumbled or fallen because of dizziness? _____
8. Do you know of anything that will:
 Stop your dizziness or make it better? If so, what? _____
 Make your dizziness worse? If so, what? _____
 Bring on an attack? If so, what? _____
9. Did you ever injure your head? _____
10. Do you take any medications regularly?

Allergy pills?	Yes/No	Tranquilizers?	Yes/No
Decongestants?	Yes/No	Pain pills?	Yes/No
Antihistamines?	Yes/No	Antibiotics?	Yes/No
Aspirin?	Yes/No		
Dizziness pills?	Yes/No		
High blood pressure meds?	Yes/No		
11. Have you had any intravenous antibiotics or chemotherapy? _____
12. Do you use tobacco in any form? _____
13. Have you worked in a noisy environment? How long? _____
14. Do you suffer easily from motion sickness? _____
15. Do you experience migraines? _____
16. Do you have neck/back discomfort or injury? _____
17. Do you have any problems with your vision? _____
18. Do you have any heart problems? Family history? _____
19. Do you have high blood pressure? Family history? _____
20. Do you have diabetes? Family history? _____

III. Check the appropriate box if you have had any of the following:

	RIGHT EAR	LEFT EAR	BOTH EARS
Hearing loss			
Difference in pitch of sounds			
Distortion of hearing			
Noise in ears			
Fullness or pressure in your ear			
Pain in your ear			
Drainage from your ear			
	RIGHT EYE	LEFT EYE	BOTH EYES
Blurred vision			
Double vision			
	RIGHT	LEFT	BOTH
Numbness in hands or feet			
Weakness in arms or legs			
	YES	NO	
Tingling around mouth or face			
Loss of consciousness or blackouts			
Fainting			
Convulsion or seizure			
Hyperventilate before symptoms			

IV. Vertigo Functional Level Scale:

Check the **best choice** that best applies regarding your current state of overall function, not just during attacks:

_____ 1. My dizziness has no effect on my activities at all.

_____ 2. When I am dizzy I have to stop what I am doing for a while, but it soon passes and I can resume activities. I continue to work, drive, and engage in any activity I choose without restriction. I have not changed any plans of activities to accommodate my dizziness.

_____ 3. When I am dizzy, I have to stop what I am doing for a while, but it does pass and I can resume activities. I continue to work, drive, and engage in most activities I choose, but I have had to change some plans and make some allowance for my dizziness.

_____ 4. I am able to work, drive, travel, take care of a family, or engage in most activities, but I must exert a great deal of effort to do so. I must constantly make adjustments in my activities and budget my energies. I am barely making it.

_____ 5. I am unable to work, drive, or take care of a family. I am unable to do most of the active things that I used to. Even essential activities must be limited. I am disabled.

_____ 6. I have been disabled for 1 year or longer and/or I receive compensation (money) because of my dizziness or balance problem.