Kernodle Clinic,
A Duke Medicine Practice

Dr. Hemang Shah, MD
Dizziness Questionnaire

Circle the word that best describes your symptom: Disequilibrium, giddiness, unsteadiness, imbalance, vertigo, light headedness, etc.
Describe your symptom: ____
____
____
____

- Dizziness began: _____ days / weeks / months / years ago OR specific date: ___/___/______.

- How often does it happen? _____ Per day / week / month / year // most or all the time

- How long does it last? _____ seconds / minutes / hours

- Do you ear symptoms such as: ear pressure, ear pain, discharge from ear, ringing in the ear or hearing loss.

- Dizziness occurs while moving / standing stationary / sitting.

- Did you have an attack of fairly severe dizziness lasting 3-7 days at the onset? Y / N

- Is there associated headache? Yes / No, If yes: it is preceded by / followed by / not related to dizziness.

- Have you developed numbness / tingling / weakness in your legs?

- Dizziness is exacerbated by:

any motion	bending over	head back	lying down
rolling in bed to left	rolling in bed to right	standing up	turning head

- Dizziness began following:

head injury	fall	car accident	viral infection
meningitis	stroke	high fever	ear infection
ear surgery	heart surgery	vaccination	drug reaction

- Which medications you have tried for dizziness? :

Meclizine Antivert Plavix Aspirin Coumadin Valium Ativan Xanax Sudafed

- What type of work up / tests / consults you have been done so far?

CT scans (brain/sinuses)	MRI (brain, cervical spine)	VNG (vestibule-nystagmogram)	
EKG	Holter Monitoring	ECHO	ENT evaluation
Cardiology evaluation	other		

- Are you taking any new medications? ? (circle): Yes / No, If yes, which: ________________________

- Are you going through any major life event / stressful situation? ? (circle): Yes / No, If yes, describe:____

- Is there anything you would like to add about your dizziness? ________________________________

- What are you most worried about your dizziness?____

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