

Evaluation Questionnaire

Patient Name _____

Date: _____

1. When did your symptoms begin? _____

2. Describe what you are experiencing.

Spinning/Rotation (Vertigo) Lightheaded Off balance Passing out/fainting
 Drunk feeling (Ataxia) Other: _____

3. How long do your symptoms last? _____

Few seconds Seconds to minutes Minutes to several hours
 Hours to days Continuous Other: _____

4. How many episodes of Vertigo have you had?

Single Multiple Never had vertigo

5. What things have been associated with your episodes?

Altered head positions Rapid Ascents Neck extension Salty foods Headaches
 Loud sounds Changes in ear pressure Rolling over in bed Migraines Pain
 Stress

6. What other symptoms do you get around the time of dizzy attacks?

Hearing loss Tinnitus Aural fullness Headaches Facial numbness Anxiety
 Nausea/vomiting Changes in vision Muscle weakness Pain Other: _____

7. I have the following medical problems:

Diabetes Strokes High blood pressure Cardiovascular Back/neck problems
 Ear surgery
 Visual difficulty Seizures Migraines MS Anxiety/Depression Cancer Motion sickness

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8. Are there any activities you are unable to do because of your symptoms?

9. Have the symptoms changed since the first episode? Yes No

If yes: Better Worse Shorter Longer More severe Less severe

10. If you have had any falls in the last year, how many falls? _____

11. What were the circumstances of the falls in the last year, if there were any falls? _____

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