

Herdman Dizziness Questionnaire¹

Name: _____ Age: _____ Date: _____

Present Occupation: _____

Describe your major problem or the reason you're seeing us.

Give the date of onset and the initial symptoms and problems you experienced when your condition first began.

If you have spells, describe a typical spell in detail. Give the frequency and detail of the spells.

What do you personally think the problem is?

1. For the problems below, mark the severity of their symptoms from 0-2. (0= not at all; 1= moderate; 2= severe)

a. Sensation of imbalance

- _____ Trouble with walking
- _____ Poor balance
- _____ Falls

b. Sense of movement of the environment around you or of movement of your own body

- _____ Rotation (spinning, tumbling, cart wheeling)
- _____ Sense of pulling or moving in a straight line in some direction
- _____ Tilt

c. Other sensations

- _____ Lightheadedness or feeling as if you might faint
- _____ Floating
- _____ Swimming
- _____ Giddiness
- _____ Rocking
- _____ Spinning inside your head
- _____ Fear or avoidance of being in public places

d. Associated symptoms

- _____ Sweating
- _____ Nausea
- _____ Vomiting
- _____ Queasiness

e. Impaired vision

- _____ Double vision
- _____ Blurred vision
- _____ Flashes of light
- _____ Jumping of vision when walking or riding in a car

2. To what extent is your dizziness brought on by the following activities?

None	Some	Severe	
___	___	___	Turning over in bed, bending over, or looking up
___	___	___	Standing up
___	___	___	Rapid head movements
___	___	___	Walking in a dark room
___	___	___	Walking on uneven surfaces
___	___	___	Loud noises
___	___	___	Cough, strain, laugh, blowing up balloons
___	___	___	Movement of objects in the environment
___	___	___	Moving your eyes while your head is still
___	___	___	Wide open spaces
___	___	___	Tunnels, bridges, supermarkets
___	___	___	Menstrual periods

3. Other questions concerning dizziness

Yes	No	
___	___	Can you bring on your dizziness voluntarily? If yes, describe.
___	___	Do you experience or have you experienced moderate to severe car or boat motion sickness? If yes, when it did first begin?
___	___	Do you now avoid or have you in the past avoided situations in which you were tumbled or spun, e.g. amusement rides, merry-go-rounds? If yes, when did this begin?
___	___	Has anyone observed jerking of your eyes during your dizzy spells?

4. Have you ever had any of the following conditions?

Yes	No	
___	___	Infections of the ears
___	___	Difficulty with your hearing
___	___	Pain, fullness, popping or pressure in your ear
___	___	Pain, pins/needles, numbness, twitching or weakness of the face
___	___	Crossed eyes or lazy eye
___	___	Ringling in your ears (Tinnitus)

If you answered yes to any of these, please give details here.

If you answered yes to ringing in your ears, please answer these additional questions.

Right	Left	Both	Ringling or tinnitus is primarily in which ear?
Steady	Pulsating		How is the ringing or tinnitus perceived?
High	Low		What is the pitch of the ringing or tinnitus?
_____			How often over the past 6 months have you experienced the ringing/tinnitus?
_____			How long does it last each time?

5. REVIEW OF SYSTEMS: Within the past 6 months, have you noted any of the following?

- | Yes | No | |
|-----|-----|---|
| ___ | ___ | Significant loss in strength |
| ___ | ___ | Significant loss of energy |
| ___ | ___ | 10 pounds or more weight change, up or down. Explain below. |
| ___ | ___ | Significant memory loss (amnesia) |
| ___ | ___ | Significant change in handwriting |
| ___ | ___ | Pins and needles, numbness in arms or legs |
| ___ | ___ | Muscle or joint aches. Explain below. |
| ___ | ___ | Urinary incontinence, leakage of urine |
| ___ | ___ | Problems with sleeping |
| ___ | ___ | Shortness of breath |
| ___ | ___ | Trouble chewing |
| ___ | ___ | Trouble swallowing |
| ___ | ___ | Trouble speaking |
| ___ | ___ | Incoordination |
| ___ | ___ | Irregular or rapid heartbeat |
| ___ | ___ | Headaches |

If you answered yes to any of these, please give details.

If you answered yes to headaches, please answer these additional questions:

- _____ Approximate age the headaches began
- _____ Number per month
- _____ Pain intensity 0-10, with 0 = no headache and 10 = most severe

Since the onset of headaches, have you had at least 5 headaches that

- | Yes | No | |
|-----|-----|--|
| ___ | ___ | Lasted at least 4 hours |
| ___ | ___ | Started on one side of the head Which side? Left Right |
| ___ | ___ | Were throbbing or pulsating in quality |
| ___ | ___ | Were severe enough to interfere with your schedule |
| ___ | ___ | Were aggravated by routine physical activity |
| ___ | ___ | Were associated with nausea or vomiting |
| ___ | ___ | Were aggravated by bright lights or loud noises |

6. PAST MEDICAL HISTORY

List any injuries you have had due to trauma and give the dates they occurred.

List all surgeries and give the dates they were performed.

P4. HDQ Name: _____

Have you been exposed to any of the following?

- | Yes | No | |
|-------|-------|--|
| _____ | _____ | Child abuse |
| _____ | _____ | Intravenous antibiotics |
| _____ | _____ | Loud noises, e.g., guns, machinery, loud music |
| _____ | _____ | Drug therapy for cancer |

Have you had any of the following infections?

- | Yes | No | |
|-------|-------|------------------------------|
| _____ | _____ | Syphilis or venereal disease |
| _____ | _____ | Lyme disease |
| _____ | _____ | Meningitis |
| _____ | _____ | Other infections |

Has your past or present health been affected by any of the following conditions?

- | Yes | No | |
|-------|-------|--------------------------------------|
| _____ | _____ | Heart problems |
| _____ | _____ | Diabetes |
| _____ | _____ | Thyroid disorder |
| _____ | _____ | Psychiatric condition |
| _____ | _____ | Depression |
| _____ | _____ | High cholesterol |
| _____ | _____ | High blood pressure |
| _____ | _____ | Low blood pressure |
| _____ | _____ | TMJ, jaw pain or grinding your teeth |
| _____ | _____ | Loss of consciousness, faints |
| _____ | _____ | Seizures or convulsions |
| _____ | _____ | Arthritis |
| _____ | _____ | Neck pain |

If you answered yes to any of these, please give details.

List all major illnesses, injuries and surgeries not described above.

7. SOCIAL HISTORY

- | Yes | No | |
|-------|-------|--|
| _____ | _____ | Do or did you use alcohol?
If yes, how much? |
| _____ | _____ | Do you now or did you ever smoke?
If yes, how many packs per day?
At what age did you start?
If you quit, at what age did you quit? |
| _____ | _____ | Do you drink caffeinated beverages, e.g., coffee, tea, soda?
If yes, how many cups, cans or bottles per day? |

P5. HDQ Name: _____

8. FAMILY HISTORY

Which family members have or had the following conditions?

Father	Mother	Child	
___	___	___	Headaches
___	___	___	Meniere's syndrome
___	___	___	Hearing loss
___	___	___	Vertigo or dizziness
___	___	___	Balance problems or tremor
___	___	___	Diabetes
___	___	___	Cancer or brain tumors
___	___	___	Stroke
___	___	___	Heart disease
___	___	___	High blood pressure
___	___	___	Psychiatric disorder
___	___	___	Other neurologic diseases

If your parents are alive, what are their ages? Mother _____ Father _____

If your parents have died, at what age and from what cause? Mother _____ Father _____

9. MEDICATIONS

List all your current medications including hormones, birth control pills, special diet supplements, etc.

10. ALLERGIES TO MEDICATIONS

List medications that cause you to have an allergic reaction. Note the type of reaction to each medication, e.g., skin rash or difficulty breathing.

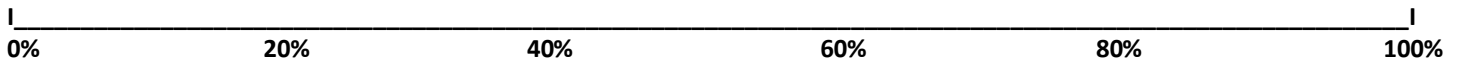
11. Answer the following questions. Have you had

No	Yes	Result	Date	
___	___	_____	_____	Hearing test
___	___	_____	_____	Caloric test (warm/cold water or air in the ear)
___	___	_____	_____	Evaluation by a neurologist
___	___	_____	_____	Evaluation by an ENT, ear doctor
___	___	_____	_____	Evaluation by an ophthalmologist, eye doctor
___	___	_____	_____	MRI of the head

P6. Name: _____

12. MULTI-DIMENSIONAL DIZZINESS INVENTORY: Section A

In the last 6 months, indicate on the line below, the percentage of the time that dizziness has interfered with your activities.



Instructions: Answer the following questions about your dizziness and how it affects your life. Circle the number on the scale under each question to indicate how that question applies to you.

a. Rate the level of your dizziness at the present moment. Date: _____ Time: _____

1	2	3	4	5
None	Slight	Moderate	Quite a bit	Extreme

b. Since your dizziness began, how much has your dizziness changed your ability to work?

1	2	3	4	5
Not at all	Slightly	Moderately	Quite a bit	Extremely

Did your dizziness force you to retire?

c. How much has dizziness changed your ability to do household chores?

1	2	3	4	5
Not at all	Slightly	Moderately	Quite a bit	Very much

d. Does your dizziness significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing or to parties?

1	2	3	4	5
Not at all	Slightly	Moderately	Quite a bit	Very much so

e. To what extent does dizziness prevent you from driving your car?

1	2	3	4	5
Not at all	Slightly	Moderately	Quite a bit	Severely

MULTI-DIMENSIONAL DIZZINESS INVENTORY: Section B

In this section, rank the intensity of your self-perceptions and emotions as given by the terms below on a scale of 0 to 5. Place your rating in the space next each descriptor.

1	2	3	4	5
Very slightly or Not at all	A little	Moderately	Quite a bit	Extremely

___ Interested	___ Guilty	___ Inspired	___ Active
___ Distressed	___ Scared	___ Nervous	___ Afraid
___ Excited	___ Irritable	___ Determined	___ Hostile
___ Upset	___ Alert	___ Attentive	___ Enthusiastic
___ Strong	___ Ashamed	___ Jittery	___ Proud