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Herdman Dizziness Questionnaire[1]

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**

P2 HDQ Name:_____

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
____	____	Ringing 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	Ringing 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?

P3 HDQ Name:_____

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 ophthamalogist, 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.

I_____I
0% 20% 40% 60% 80% 100%

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

1. In *Vestibular Rehabilitation*, 3rd Ed. Herdman, SJ, ed, F.A. Davis, Philadelphia, 2007.