QUESTIONNAIRE

DESMOND FALL RISK QUESTIONNAIRE

Please answer all questions

Name _____ Date _____

	YES	NO	
1.	❑	❑	Have you had a fall or near fall in the past year?
2.	❑	❑	Do you have a fear of falling that restricts your activity?
3.	❑	❑	Do you experience dizziness or a sensation of spinning when you lie down, tilt your head back, or roll over in bed?
4.	❑	❑	Do you feel uneasy or unsteady when walking down the aisle of a supermarket, or in an area congested with other people?
5.	❑	❑	Do you have difficulty walking in the dark, or on uneven surfaces such as gravel or a sloped sidewalk?
6.	❑	❑	Do your feet or toes frequently feel unusually hot or cold, numb or tingly?
7.	❑	❑	Do you wear bifocal or trifocal glasses, or is your vision notably better in one eye?
8.	❑	❑	Do you experience loss of balance, or a lightheaded/faint feeling when you stand up?
9.	❑	❑	Do you take medication for depression, anxiety, nerves, sleep or pain?
10.	❑	❑	Do you take four or more prescription medications daily?
11.	❑	❑	Do you feel like your feet just won't go where you want them to go?
12.	❑	❑	Do you feel like you can't walk a straight line, or are pulled to the side while walking?
13.	❑	❑	Has it been longer than six months since you participated in a regular exercise program?
14.	❑	❑	Do you feel that no one really understands how much dizziness and balance problems affect your quality of life?
15.	❑	❑	Are you interested in improving your balance and mobility?

QUESTIONNAIRE

DIZZINESS HISTORY QUESTIONNAIRE

Name:_____ Age:_____ Date: _____

WHEN was the first time you ever had dizziness?_____

_____

WHAT were the circumstances? _____

WHEN was the last time you experienced dizziness? _____

WHAT were the circumstances? _____

_____

CURRENTLY, MY DIZZINESS...

- ❑ is constant.
- ❑ is always there, but changes in intensity.
- ❑ comes in episodes.

IF COMES AND GOES:

How long does it typically last? ___ seconds / minutes / hours (Circle ONE)

How often does it typically occur? _____ times per: hour / day / week / month / year

MY DIZZINESS MOSTLY CONSISTS OF...(Check ALL that apply)

- ❑ spells of spinning with nausea.
- ❑ off-balance sensation.
- ❑ a light-headed or near faint sensation.
- ❑ other. Please explain _____

BETWEEN EPISODES I FEEL...(Check ONE)

- ❑ dizzy or off balance all the time.
- ❑ normal.
- ❑ other. Please explain _____

MY EPISODES OCCUR...(Check ALL that apply)

- ❑ spontaneously. Nothing I do seems to bring them on or turn them off.
- ❑ only when standing or walking.
- ❑ in relation to any head motion.
- ❑ only in certain head positions. Please describe _____

WHEN I ROLL OVER IN BED...(Check ONE)

- ❑ nothing unusual happens.
- ❑ the room seems to spin sometimes.

IS THERE ANYTHING THAT YOU CAN DO TO MAKE YOUR DIZZINESS GO AWAY?
(sit, lay down, close eyes...)

Please explain: _____

_____

QUESTIONNAIRE

DIZZINESS HISTORY QUESTIONNAIRE CONT.

CIRLCLE ALL THAT APPLY:

I have hearing difficulty *Right / Left / Both*
I have ear fullness *Right / Left / Both*
I have ringing or other sounds *Right / Left / Both*
I have had ear surgery *Right / Left / Both*

CIRCLE YES OR NO

- Did you have cold, flu or virus type symptoms shortly before the onset of your dizziness? .....YES / NO
- Did you cough, lift, sneeze, fly in a plane, swim under water or have a head trauma shortly before the onset of your dizziness? .....YES / NO
- Were you exposed to any irritating fumes, paints, etc. at the onset of your dizziness? .....YES / NO
- Do you get dizzy when you have not eaten for a long time? .....YES / NO
- Is your dizziness connected with your menstrual period?.....YES / NO
- Did you get new glasses recently? .....YES / NO
- I consider myself to be an anxious or tense type of person... .....YES / NO

IN THE PAST YEAR I HAVE HAD...(CHECK ALL THAT APPLY)

❑ loss of consciousness ❑ occasional loss of vision ❑ seizures or convulsions
❑ severe pounding headache or migraine ❑ slurring of speech ❑ difficulty swallowing
❑ palpitations of the heartbeat ❑ weakness in one hand, arm or leg ❑ tingling around mouth
❑ double vision ❑ tendency to fall ❑ spots before the eyes ❑ loss of balance when walking

I HAVE OR HAVE HAD...(CHECK ALL THAT APPLY)

❑ Diabetes ❑ Stroke ❑ High blood pressure ❑ Migraine headaches ❑ Arthritis
❑ A neck and/or back injury ❑ Irregular heartbeat ❑ Allergies

PLEASE CHECK BELOW FOR ANY MEDICATIONS YOU HAVE TRIED FOR DIZZINESS OR ARE CURRENTLY TAKING:

	Taken in past	Taking now	Helps
Antivert (Meclizine)	___	___	___
Valium (Diazepam)	___	___	___
Dyazide "water pills"	___	___	___

HAVE YOU EVER BEEN PREVIOUSLY EVALUATED FOR DIZZINESS?

Where? When? _____

_____