MINDS
Mississauga Institute of Neurological Disorders and Stroke

Unit #9, 2145 Dunwin Drive
Mississauga, Ontario L5L 4L9

Phone: (905) 896-3000
Fax: (905) 896-8906
Website: www.mindsneurology.com

DIZZINESS SURVEY VESTIBULAR ASSESSMENT SCALE

PATIENT INFORMATION

Last Name:	First Name:	Gender: □ Male □ Female
Date of Birth (DD/MM/YYYY):	Home #:	Cell #:
Health Card #:		
□ OHIP □ Private Pay □ Motor Vehicle Accident	□ Emergent □ Urgent □ Non-Urgent	

A) Please read each question and check the box that most describes your answer.

Onset: _____
Duration: ___sec/___min/___hr/___days

1.	**Your dizziness is best described as:**	□ Spinning □ Sensation of movement □ Lightheadedness □ Unsteadiness □ Loss of balance □ Sudden falls
2.	**How frequently do you experience dizziness or imbalance?**	□ Often (days) □ Sometimes (weeks) □ Rare (months)
3.	**Do you feel dizzy when you bend down, look up, or roll over in bed?**	□ Often (days) □ Sometimes (weeks) □ Rare (months)
4.	**Do you feel lightheaded when you are walking or climbing stairs?**	□ Often (days) □ Sometimes (weeks) □ Rare (months)
5.	**Do you feel dizzy or unsteady when you move your head quickly?**	□ Often (days) □ Sometimes (weeks) □ Rare (months)
6.	**Is your dizziness accompanied by headache, nausea, blurred vision, noise in your ears?**	□ Often (days) □ Sometimes (weeks) □ Rare (months)
7.	**Have you had a recent loss of, or decrease, in your hearing or vision?**	□ Often (days) □ Sometimes (weeks) □ Rare (months)
8.	**Do you ever fall or feel like you are about to fall for no apparent reason?**	□ Often (days) □ Sometimes (weeks) □ Rare (months)
9.	**Do you fear falling?**	□ Often (days) □ Sometimes (weeks) □ Rare (months)
10.	**Do you feel dizzy while rising from a seated or lying position?**	□ Often (days) □ Sometimes (weeks) □ Rare (months)
11.	**Does walking down the aisle of supermarket or stopping next to moving traffic make you dizzy?**	□ Often (days) □ Sometimes (weeks) □ Rare (months)

B) Please read each question and check the box that most describes your answer.			
1. Do you suffer from blurred vision?	□ Always □ Frequently □ Often □ Sometimes □ Never	**10. When looking up from reading, do objects appear momentarily blurred?**	□ Always □ Frequently □ Often □ Sometimes □ Never
2. Do you fall asleep while reading?	□ Always □ Frequently □ Often □ Sometimes □ Never	**11. Do you ever feel that both of your eyes are not working together?**	□ Always □ Frequently □ Often □ Sometimes □ Never
3. Does your vision seem worse at the end of the day than in the morning?	□ Always □ Frequently □ Often □ Sometimes □ Never	**12. Does prolonged reading or close work give you headaches?**	□ Always □ Frequently □ Often □ Sometimes □ Never
4. Do you lose your concentration while reading?	□ Always □ Frequently □ Often □ Sometimes □ Never	**13. Do you ever have car sickness?**	□ Always □ Frequently □ Often □ Sometimes □ Never
5. Do you experience double vision?	□ Always □ Frequently □ Often □ Sometimes □ Never	**14. Is reading in a moving vehicle difficult?**	□ Always □ Frequently □ Often □ Sometimes □ Never
6. Do you often close an eye when reading?	□ Always □ Frequently □ Often □ Sometimes □ Never	**15. Do your eyes work equally well?**	□ Always □ Frequently □ Often □ Sometimes □ Never
7. Do your eyes feel tired at the end of the day?	□ Always □ Frequently □ Often □ Sometimes □ Never	**16. Do you get tired when reading?**	□ Always □ Frequently □ Often □ Sometimes □ Never
8. Do words seem to run together when reading?	□ Always □ Frequently □ Often □ Sometimes □ Never	**17. After you have read awhile, does the print begin to appear blurry?**	□ Always □ Frequently □ Often □ Sometimes □ Never
9. When reading, do you ever find that you skip or repeat lines?	□ Always □ Frequently □ Often □ Sometimes □ Never	**18. Do you have eye strain?**	□ Always □ Frequently □ Often □ Sometimes □ Never