Anne Arundel ENT &

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Tel: 410-573-9191 Fax: 410-573-9510

600 Ridgely Ave., Suite 110
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DIZZINESS QUESTIONNAIRE

Patient Name:_____ Date:_____

How long you have had this problem: ____Years ____Months ____Days

Are you dizzy all of the time? Yes ☐ No ☐ With motion only ☐

Is the dizziness room spinning or off balance? ☐ Yes ☐ NO

Does the dizziness occur in attacks? Yes ☐ No ☐ With motion only ☐

If yes: How often do you have an attack?_____

How long does the average attack last?_____

When was the first time you had an attack?_____

What were you doing when you became dizzy?_____

Are you completely free from dizziness between attacks? Yes ☐ No ☐

When you are dizzy

Does your ear feel plugged or stopped up? Yes ☐ No ☐

Does your ear ring or buzz? Yes ☐ No ☐

Do you feel a spinning sensation? Do you Yes ☐ No ☐

black out or faint? Yes ☐ No ☐

Do you have hearing loss? If so which side Yes ☐ NO ☐

Do you have a tendency to fall or veer to one side when walking?_____

Check any of the following that describes your dizziness:

Disorientation	☐	Tendency to fall	☐	Lightheadedness	☐
Room spinning	☐	Weakness	☐	Occurs with movement in bed	☐
Blackout or faint	☐	Awakens you from sleep	☐	Loss of balance when walking	☐
Occurs at night	☐	Loss of memory	☐	Occurs during the day	☐

Have you ever had an injury to your head? ☐ Yes ☐ No

If yes:

When was the injury?_____

What happened?_____

Were you knocked unconscious? ☐ Yes ☐ No

Was your skull fractured? ☐ Yes ☐ No

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Check any of the following that occur before, during, or after you have a dizziness attack:

Headaches	☐	Pain in your ear(s)	☐	Nausea	☐
Numbness in your face	☐	Difficulty with speech	☐	Vomiting	☐
Blurred Vision	☐	Noise in your ear(s)	☐	Weakness in arms or legs	☐
Pressure in your ear(s)	☐	Pain in neck or shoulder	☐	Excessive sweating	☐

Check if you have any of the following:

Diabetes	☐	Heart trouble	☐	Asthma	☐
Stroke	☐	Allergies	☐	Tuberculosis	☐
Sinus trouble	☐	Kidney trouble	☐	High blood pressure	☐
Venereal Disease	☐	AIDS or HIV+	☐		

Check any of the following that pertain to your vision:

Wear glasses	☐	Wear contact lenses	☐	Have glaucoma	☐
Have cataracts	☐	Cannot close both eyes	☐		

When was your last eye exam?_____

Have you seen your primary care doctor about your dizziness? Yes ☐ No ☐

If yes:

Do they think your dizziness is medication related? Yes ☐ No ☐

Do they think your dizziness is heart related? Yes ☐ No ☐

Do they think your dizziness is ear related? Yes ☐ No ☐

What treatment did they suggest?_____

Did the treatment decrease your dizziness? Yes ☐ No ☐