Balance Disorder Questionnaire

Name _____ Date _____

Address _____

_____

Date of Birth _____ Phone #_____

Primary Care Physician _____ Referring Physician_____

---

1) Briefly describe the problem you are encountering: _____

_____

_____

2) Have you consulted any other physician regarding your dizziness? Y N

If yes, please list and describe findings: _____

_____

3) Has any testing been performed to assist in the diagnosis?.....Y N

If yes, please list: _____

Dizziness History

1) Is your dizziness a sensation of: (Please Circle)

a. Turning..... Y N
b. Lightheadedness.....Y N
c. Disorientation.....Y N
d. Loss of Balance..... Y N
e. Room Spinning..... Y N
f. Is your dizziness different than these listed?..... Y N

If yes, please describe: _____

_____

2) When did your dizziness begin? _____

3) Did it happen: Suddenly? Gradually?

4) Can you recall what you were doing when the dizziness first occurred?..... Y N

If yes, please describe: _____

_____

5) Was it accompanied by: Nausea? Vomiting?

6) Do you know of anything that may have caused or been related to your dizziness?..... Y N

If yes, please describe: _____

7) Is your dizziness: Continuous? Periodic?

8) Are you dizzy right now? .....Y N

9) When did the last attack occur? _____

10) Is the dizziness brought on or made worse by sudden movement or change in position? ...Y N

If yes, please describe the positions and changes that take place: _____

_____

_____

11) How long does a typical attack last? _____

12) Have your symptoms changed over the past 6 weeks? _____

13) Rate your Dizziness on a scale of 1-10 (1 – no dizziness; 10 – worst): _____

14) Have you experienced any of the following:

a. Headache .....Y N
b. Pressure in head.....Y N
c. Pressure in back or neck ..... Y N
d. Numbness in face..... Y N
e. Blurred vision .....Y N
f. Fainting spell.....Y N
g. Chest pain .....Y N
h. Loss of memory .....Y N
i. Difficult concentrating ...Y N
j. Shortness of breath..... Y N
k. Loss of energy .....Y N
l. Fear of falling .....Y N
m. Tingling in face or hands...Y N

15) Are there any factors that make your dizziness worse? .....Y N

If yes, please describe: _____

16) Are there any factors that make your dizziness better? .....Y N

If yes, please describe: _____

Hearing

1) Do you have a hearing loss: .....Y N

If yes, please describe: _____

2) Did your hearing loss begin at the same time as your dizziness? .....Y N

3) Was your hearing loss: Sudden? Gradual?

4) Does your hearing fluctuate? .....Y N

5) Is there or have you had any pressure in your ears?.....Y N

6) Is there any pain in your ears?.....Y N

7) Have you had a history of ear infections? .....Y N

8) Have you had your hearing tested previously by an audiologist? .....Y N

If yes, what were the results? _____

_____

9) Do you wear hearing aids? .....Y N

If yes, what type: _____

General History

1) Have you ever had a head or ear injury?..... .....Y N

If yes, please answer the following questions:

a. Have you ever had surgery to your head or ears? .....Y N

b. Did you have a concussion? .....Y N

c. Were you knocked out (unconscious)? .....Y N

d. Did you feel dizzy? .....Y N

2) Have you been exposed to excessive noise (machinery, gunfire, etc.)? .....Y N

3) Have you now, or in the past, had any of the following illnesses?

a. Diabetes .....Y N

b. High Blood Pressure.....Y N

c. Heart Disease .....Y N

d. Stroke .....Y N

e. Kidney Failure .....Y N

f. Glaucoma .....Y N

g. Mumps .....Y N

h. Measles .....Y N

i. High Fever .....Y N

j. Seizure Disorder .....Y N

k. Migraine Headaches .....Y N

4) Any other illnesses? _____

_____

5) Please list all medications you are taking: _____

_____

_____

Thank you for taking the time to fill out this questionnaire to enable us to serve you better!