Dizziness and Balance Questionnaire

NAME:_____DATE_____

Do you have any of the following (please off your answers)

( )yes ( )no Dizziness (includes vertigo, light-headedness, woozy)
( )yes ( )no Imbalance or Dysequilibrium (see next page to provide details)
( )yes ( )no Falls
( )yes ( )no Difficulty hearing Indicate which ear right left both
( )yes ( )no Noise in ears Indicate which ear right left both
( )yes ( )no Headaches (see next page to provide details)
( )yes ( )no Neck or shoulder aches or stiffness (see next page to provide details)
( )yes ( )no Ever had motion sickness (see next page to provide details)

Have you ever had any of the following?

( )yes ( )no Head and/or neck injuries? Include dates:_____
( )yes ( )no Ear, Brain, or Neck Surgery? Include dates:_____

Only if you have dizziness, please answer all of the following questions and fill in the blanks.
Describe your dizziness:_____

( )yes ( )no Do things around you appear to be whirling or moving?
( )yes ( )no Do you feel as though you are turning or moving?
( )yes ( )no Is your dizziness a FLOATING SENSATION?
( )yes ( )no Is your dizziness accompanied by DISORIENTATION?
( )yes ( )no Is your dizziness accompanied by difficulty with your BALANCE?
( )yes ( )no Is your dizziness accompanied by NAUSEA?
( )yes ( )no Is your dizziness accompanied by HEADACHE?
( )yes ( )no Is your dizziness accompanied by a HEARING change?
( )yes ( )no Is your dizziness accompanied by NOISES in your EAR?
( )yes ( )no Is your dizziness accompanied by PAIN in your NECK?

When did you first ever have dizziness?_____

How often are you dizzy? ( ) all the time ( ) in episodes ( ) when changing positions

If your dizziness occurs in episodes, how long does an episode last? (check all that apply)
( ) seconds ( ) minutes ( ) hours ( ) days ( ) Other:_____

When were your last 2 episodes of dizziness?_____

Do you have any warning that an episode will occur? ( )yes ( ) no ( ) Specify:_____

Which of the following can make your dizziness worse or can trigger an episode? (check all that apply)

_when you're fatigued	_when you first wake up	_at the end of the day
_menstrual period	_with a weather change	_ with stress
_rolling over in bed to R to L	_moving quickly	_with worry
_in the car	_turning your head	_watching thing move past you
_bending or stooping over	_looking up	_coughing or straining

Other specify:_____

Dizziness and Balance Quesitonnaire

Name:_____Date:_____

If you have difficulty with you BALANCE, please answer all of the following questions and fill in the blanks.

When did you first begin to lose your balance?_____
How has you balance been affected? ( )Suddenly ( )Gradually ( )In episodes
Does DIZZINESS accompany your loss of balance? ( )Always ( )Sometimes ( )Never
Do you feel PUSHED or do you VEER when you walk? ( )To the Right ( )To the Left ( ) Either side

If you have difficulty with you HEARING, please answer all the following questions and fill in the blanks.

When did your hearing first begin to change?_____
How has your hearing changed? ( )Suddenly ( ) Gradually ( ) In episodes
If your hearing loss occurs in episodes, how long does a typical episode last?_____
Can NOISES in your ear(s) accompany hearing loss? ( )Usually ( )Sometimes ( ) Never
Can VERTIGO or DIZZINESS accompany hearing loss? ( )Usually ( )Sometimes ( )Never
Can fullness in your ear(s) accompany hearing loss? ( )Usually ( )Sometimes ( ) Never

If you have HEADACHES, please answer all of the following questions and fill in the blanks.

How old were you when you had your first headache? ( )Young Child ( )Teens or 20's ( ) Recently
How often do they happen? _____times ( )Daily ( )Weekly ( )Monthly ( )Yearly
How long do they last? _____ ( )Seconds ( )Minutes ( )Hours ( )Days ( )Weeks
Where do you get them? ( )Eyes ( )Sinuses ( )Forehead ( )Temple ( )Back of head
Are they ever associated with DIZZINESS? ( )Always ( )Sometimes ( )Never
Are they ever associated with VISUAL CHANGES? ( )Always ( )Sometimes ( )Never
Do you feel SICK or NAUSEATED with them? ( )Always ( )Sometimes ( )Never
Does movement sound or light make them worse? ( )Always ( )Sometimes ( )Never
Are they ever associated with VISUAL PATTERNS? ( )Always ( )Sometimes ( )Never
Or lights / black spots before your eyes? ( )Always ( )Sometimes ( )Never

If you have NECK PAIN or NECK STIFFNESS, please answer all the following questions and fill in the blanks.

When did you first begin to have neck problems?_____
Does turning your head seem RESTRICTED? ( )None ( )Right side ( )Left side ( ) Either side
Does PAIN in your neck keep you from falling asleep? ( )Always ( )Sometimes ( )Never
Does DIZZINESS occur when you turn your head? ( )Always ( )Sometimes ( )Never
Does PAIN in your neck accompany your DIZZINESS? ( )Always ( )Sometimes ( )Never

If you ever had MOTION SICKNESS, please mark the situations which have caused you to feel sick:

( )Amusement park rides ( )On boats in rough water ( )On boats in calm water ( )Around water
( )Riding in the car(front) ( )Riding in the car (back) ( )Reading in the car
( )As a child in parents care ( )Motion sickness elswhere (specify)_____

Is there anything else you would like us to know about your dizziness? (specify)_____
_____

Patient Signature:_____