Dizziness and Balance Disorder Patient Questionnaire

Name_____ Date of Birth_____Age_____Date_____
Address_____ City, State, Zip_____
Home Phone _____ Work Phone_____
Referring Physician_____ MR#_____

Please answer the following questions and bring the answers to your appointment. There is room at the end of each section for additional comments. Please give necessary details for "yes" answers. We realize that this form is lengthy and takes time to complete, but when it is carefully filled out, it provides us with needed background information and allows us to devote more time to examining you and discussing your concerns regarding your health problems. If multiple choice answers are provided, please circle all that apply for each question.

1. In your family, is there a history of any of the following?

Hearing loss	Dizziness	Ear surgery	Ringing in the ears
Brain tumors	Headaches	Migraine	Balance disorders

2. Have you ever been told by a healthcare provider that you have or had any of the following?

Diabetes	High blood pressure	Low blood pressure	Thyroid problems
Low blood sugar	Depression	Anxiety disorders	Blood diseases
Anemia	Skin rash	Hepatitis	Syphilis
High cholesterol	Meningitis	Heart problems	Seizures
Arthritis	Mononucleosis	Lyme diseases	Other infections (specify)

3. Have you ever had any head or neck injuries or whiplash?

Yes No When_____

4. When did your current dizzy/balance symptoms begin?_____

5. Have you had dizziness/balance problems prior to the current problem? Yes No

When_____

6. Were your previous symptoms similar to the current problem or different?

7. How often do your dizziness/balance symptoms occur?

once a year	once a month	once a week	several times per week
once a day	several times per day	constant symptoms	

8. Do your symptoms occur or get worse any particular time of the day or night? Yes No

When_____

9. Do your symptoms improve at any particular time of the day or night? Yes No

When_____

10. How long do your dizziness/balance symptoms usually last?

months weeks days hours minutes seconds

11. Do you have any of the following symptoms with your dizziness/balance problems?

Nausea	Vomiting	Ear pressure	Ear fullness
Ear pain	Ringing in the ears	Hearing loss	Hearing improvement
Slurred speech	Headaches	Double vision	Loss or change in vision
Blackouts	Numbness or weakness in face, arms or legs		Memory loss
Weakness	Faintness	Difficulty chewing, swallowing or speaking	

12. Do you have allergies and/or sinus problems? Yes No

13. What surgeries, if any have you had, and when?

14. What medications are you currently taking (prescription and over-the-counter)?

15. What other medications (in addition to the ones listed above) have you taken in the past six months (prescription and over-the-counter)?

16. Do you have any of the following symptoms? If so, please describe in more detail.

Difficulty walking or with balance

Sense of spinning, tumbling or cartwheeling

Moving, tilt or rotation of the world

Double, blurred or jumping vision

17. Are your symptoms ever affected or brought on by any of these?

Changes in position of head or body	Rapid head movements	Standing up
Walking on rough or uneven surfaces	Walking in a dark room	Lying down
Elevators and/or escalators	Climbing stairs or ladders	Loud noises

Airplane, boat or car travel	Cough, sneeze, strain or laugh	Dim lights
Shopping malls, narrow or wide spaces	Blowing up balloons	Exercise
Watching moving objects around you	Fluorescent lights	Smoking
Foods: eating or not eating; salt or sugar ;	Monosodium glutamate	Caffeine
Depression, anxiety, nerves, stress	Menstrual periods	Alcohol

18. Without using the word, “dizzy,” how would you best describe your symptoms? (few words)