



Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

### Patient Questionnaire

Equilibrium disorders may appear with a variety of symptoms. Some individuals may experience dizziness or vertigo while others may have imbalance or unsteadiness. Please spend a few minutes answering the questions regarding your history and symptoms. Answer the questions to the best of your ability but please be assured that how you answer will not affect your evaluation.

How or when did your problem first occur? \_\_\_\_\_

How long did it last? \_\_\_\_\_

I. Do you experience any of the following sensations? Please read the entire list first. Then put an 'x' in either the first box for YES or the second box for NO to describe your feelings most accurately.

YES      NO

- Do you experience motion, air or sea sickness?
- Did you have motion sickness as a child?
- Do you have a family history of motion sickness? parent? \_\_\_ sibling? \_\_\_ child? \_\_\_
- Do you have migraine headaches?
- Were you exposed to any solvents, chemicals, etc.?
- Have you ever fallen? How many times? \_\_\_\_\_
- Where? \_\_\_\_\_ Inside the home? \_\_\_\_\_ Outside the home? \_\_\_\_\_
- Are you afraid of falling?

II. If you have dizziness, please check the box for either YES or NO, and fill in the blank spaces. If you do not experience dizziness, please go to the next section (III).

YES      NO

- My dizziness is constant? If you answered yes, please go to section III.
- If in attacks, how often? \_\_\_\_\_
- Are you completely free of dizziness between attacks?
- Do you have any warning that the attack is about to start?
- Is the dizziness provoked by head/body movement? If so, which direction? \_\_\_\_\_
- Is the dizziness worse at any particular time of the day?
- If so, when? \_\_\_\_\_
- Do you know of anything that will stop your dizziness or make it better?
- What? \_\_\_\_\_
- ..... make your dizziness worse?
- What? \_\_\_\_\_
- ..... precipitate an attack?
- What? \_\_\_\_\_
- Do you know any possible cause of your dizziness?
- What? \_\_\_\_\_

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**III. Do you experience any of the following sensations? Please read the entire list first then please check the box for either YES or NO to describe your feelings most accurately.**

- | YES                      | NO                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Light headedness?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Swimming sensation in the head?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Blacking out or loss of consciousness?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Objects spinning or turning around you?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Sensation that you are turning or spinning inside, with outside objects remaining stationary? |
| <input type="checkbox"/> | <input type="checkbox"/> | Tendency to fall..... to the right or left.   |
| <input type="checkbox"/> | <input type="checkbox"/> | Tendency to fall..... forward or backward   |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of balance when walking..... veering to the right?                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of balance when walking..... veering to the left?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have trouble walking in the dark?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have problems turning to one side or the other?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea or vomiting?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Pressure in the head?   |

**IV. If you have the sense of being off-balance, is the feeling of being off-balance:**

- |                               |                              |                             |
|-------------------------------|------------------------------|-----------------------------|
| Constant                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Spontaneous                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Induced by motion             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Induced by positional changes | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Worse with fatigue            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Worse in the dark             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Worse outside                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Worse on uneven surfaces      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Does the feeling of off balance occur when you are:

- |                             |                              |                             |
|-----------------------------|------------------------------|-----------------------------|
| Lying down or moving in bed | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sitting                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Standing                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Walking                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**V. History of Falling**

Do you or have you fallen (to the ground)?  Yes  No

If yes, please describe: \_\_\_\_\_

How often do you fall? \_\_\_\_\_

Have you injured yourself from falling?  Yes  No

If yes, please describe \_\_\_\_\_

Do you or have you had "near falls"?  Yes  No

Do you stumble, stagger, or side-step while you walk?  Yes  No

Do you find yourself drifting to one side when you walk?  Yes  No

If yes, to which side do you drift?  Right  Left

**VI. Have you ever experienced any of the following symptoms? Please check the box for either YES or NO and circle if Constant or if In Episodes.**

**YES NO**

- |                          |                          |                                     |                          |          |                          |             |
|--------------------------|--------------------------|-------------------------------------|--------------------------|----------|--------------------------|-------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Double vision?                      | <input type="checkbox"/> | Constant | <input type="checkbox"/> | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Blurred vision or blindness?        | <input type="checkbox"/> | Constant | <input type="checkbox"/> | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Spots before your eyes?             | <input type="checkbox"/> | Constant | <input type="checkbox"/> | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness of face, arms or legs?     | <input type="checkbox"/> | Constant | <input type="checkbox"/> | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Weakness in arms or legs?           | <input type="checkbox"/> | Constant | <input type="checkbox"/> | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Confusion or loss of consciousness? | <input type="checkbox"/> | Constant | <input type="checkbox"/> | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty in swallowing?           | <input type="checkbox"/> | Constant | <input type="checkbox"/> | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Tingling around the mouth?          | <input type="checkbox"/> | Constant | <input type="checkbox"/> | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty speaking?                | <input type="checkbox"/> | Constant | <input type="checkbox"/> | In Episodes |

**VII. Can any of the following make your dizziness worse or start an attack?**

- |                  |                          |     |                          |    |
|------------------|--------------------------|-----|--------------------------|----|
| Fatigue          | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Exertion         | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Hunger           | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Menstrual period | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
| Stress           | <input type="checkbox"/> | Yes | <input type="checkbox"/> | No |
- Do you have any allergies?  Yes  No  
 If yes, please list: \_\_\_\_\_

**VIII. Do you have any of the following? Please check the box for either YES or NO and circle the ear involved.**

**YES NO**

- |                          |                          |   |                          |                            |                          |           |                          |          |
|--------------------------|--------------------------|---|--------------------------|----------------------------|--------------------------|-----------|--------------------------|----------|
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty in hearing?  | <input type="checkbox"/> | Both Ears                  | <input type="checkbox"/> | Right Ear | <input type="checkbox"/> | Left Ear |
|                          |                          | When did this start? _____                                    |                          | Is it getting worse? _____ |                          |           |                          |          |
|                          |                          | Does the hearing change with your symptoms? If so, how? _____ |                          |                            |                          |           |                          |          |
| <input type="checkbox"/> | <input type="checkbox"/> | Noise in your ears?   | <input type="checkbox"/> | Both Ears                  | <input type="checkbox"/> | Right Ear | <input type="checkbox"/> | Left Ear |
|                          |                          | Describe the noise? _____                                     |                          |                            |                          |           |                          |          |
|                          |                          | Does the noise change with your symptoms? If so, how? _____   |                          |                            |                          |           |                          |          |
| <input type="checkbox"/> | <input type="checkbox"/> | Does anything stop the noise or make it better? _____         |                          |                            |                          |           |                          |          |
| <input type="checkbox"/> | <input type="checkbox"/> | Fullness or stuffiness in your ears?                          | <input type="checkbox"/> | Both Ears                  | <input type="checkbox"/> | Right Ear | <input type="checkbox"/> | Left Ear |
|                          |                          | Does this change when you are dizzy? _____                    |                          |                            |                          |           |                          |          |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in your ears?  | <input type="checkbox"/> | Both Ears                  | <input type="checkbox"/> | Right Ear | <input type="checkbox"/> | Left Ear |
| <input type="checkbox"/> | <input type="checkbox"/> | Discharge from your ears?                                     | <input type="checkbox"/> | Both Ears                  | <input type="checkbox"/> | Right Ear | <input type="checkbox"/> | Left Ear |

**Below For office staff only**