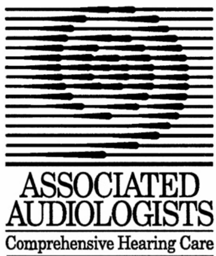

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PATIENT QUESTIONNAIRE

PATIENT NAME: ____ **DATE:** ____________________

Patients with equilibrium disorders may experience a wide variety of symptoms. These symptoms may include issues ranging from dizziness, vertigo, and lightheadedness to imbalance, unsteadiness, and falls. Please answer the questions below to the best of your ability. Some of the questions may not be applicable or easy to answer, but please respond as accurately as possible.

How or when did your problem first occur? ____

How long did it last? ____

I. Please read each of the following questions carefully and indicate your response with an 'X' in either the first box for YES or the second box for NO.

YES	NO	
☐	☐	Do you experience motion sickness, air sickness, or sea sickness?
☐	☐	Did you experience motion sickness as a child?
☐	☐	Do you have a family history of motion sickness?
☐	☐	Do you experience migraines?
☐	☐	Have you ever been exposed to solvents, chemicals, etc.?
☐	☐	Have you experienced an injury to the head? When?____________________________
☐	☐	Have you lost consciousness because of an injury to the head?
☐	☐	Have you had a neck or back injury?
☐	☐	Do you take any medications regularly?
		If yes, What? ____
		____
		____
☐	☐	Do you use alcohol? How many drinks/week?____ How often?______ Most recent?__________
☐	☐	Do you smoke? How much? ____
☐	☐	Are you diabetic? _________________ Is your blood pressure high/low? __________________

II. The next section will ask specific questions about your balance. If you do not experience issues with your balance, please skip this section and proceed to section III.

YES	NO	
☐	☐	Are you off balance?
☐	☐	Do you have difficulty walking?
☐	☐	Do you have a fear of falling?
☐	☐	Have you fallen?
		If yes, How many times? _____ When was most recent? _________________________
		Where? ____________________ Inside home? _________ Outside home? _________
☐	☐	Do you have a loss of balance when walking?
		If yes, do you veer to either the right or left? _______________________________________
☐	☐	Do you have trouble walking in the dark?
☐	☐	Do you currently or have you ever used an assistive device (cane, walker, etc)?
☐	☐	Have you ever received therapy for your balance?
		If yes, When? _____________ Where? _______________________________

(continued)

III. The next section will ask specific questions about dizziness/vertigo. If you do not experience dizziness or vertigo, please skip this section and proceed to section IV.

YES	NO	
☐	☐	Is your dizziness constant? If you answered yes, please go to section IV.
☐	☐	Does your dizziness occur in attacks?
		If yes, how often? ______________________________
☐	☐	Are you completely free of dizziness between attacks?
☐	☐	Do you have any warning that the attack is about to start?
		If yes, what? ______________________________
☐	☐	Is the dizziness provoked by a specific head/body movement?
		If yes, what direction? ______________________________
☐	☐	Is the dizziness better or worse at any particular time of the day?
		If yes, when? ______________________________
☐	☐	Do you know of anything that will stop your dizziness of make it better?
		If yes, what? ______________________________
☐	☐	Do you know of anything that will make your dizziness worse?
		If yes, what? ______________________________
☐	☐	Do you know of anything that will precipitate an attack?
		If yes, what? ______________________________
☐	☐	Do you know of any possible cause of your dizziness?
		If yes, what? ______________________________

IV. Do you currently experience any of the following sensations? Please read the entire list and check the boxes that most accurately describe your experience. You may check as many boxes as needed.

YES	NO	
☐	☐	Lightheadedness
☐	☐	A swimming sensation in the head
☐	☐	A sensation that you could black out or lose consciousness
☐	☐	Objects are spinning or turning around you
☐	☐	An internal spinning sensation, with objects around you remaining stationary
☐	☐	Nausea or vomiting
☐	☐	Pressure in the head

V. Have you ever experienced any of the following sensations? If yes, please check the appropriate box and circle either "constant" or "in episodes."

YES	NO			
☐	☐	Double vision?	Constant	In Episodes
☐	☐	Blurred vision or blindness?	Constant	In Episodes
☐	☐	Spots before your eyes?	Constant	In Episodes
☐	☐	Numbness in face, arms, or legs?	Constant	In Episodes
☐	☐	Weakness in arms or legs?	Constant	In Episodes
☐	☐	Confusion or loss of consciousness?	Constant	In Episodes
☐	☐	Difficulty swallowing?	Constant	In Episodes
☐	☐	Tingling in the face or around the mouth?	Constant	In Episodes
☐	☐	Difficulty speaking?	Constant	In Episodes

VI. Do you have any of the following symptoms? Please indicate which ear is involved.

YES	NO				
☐	☐	Difficulty hearing?	Left Ear	Right Ear	Both
		If yes, when did this start? ______________________________			
☐	☐	Does your hearing change with your other symptoms?	Left Ear	Right Ear	Both
☐	☐	Noise in your ears or head?	Left Ear	Right Ear	Both
		If yes, does the noise change with your symptoms? ______________________________			
☐	☐	Fullness, pressure, or stuffiness in your ears?	Left Ear	Right Ear	Both
☐	☐	Pain in your ears?	Left Ear	Right Ear	Both
☐	☐	Discharge from your ears?	Left Ear	Right Ear	Both
☐	☐	Have you ever had surgery on your ears?	Left Ear	Right Ear	Both
☐	☐	Have you had your hearing evaluated?			
		If yes, When? ____________________ By whom? ____________________			