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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 | |
| <input type="checkbox"/> | <input type="checkbox"/> | Is your dizziness constant? If you answered yes, please go to section IV. |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your dizziness occur in attacks?
If yes, how often? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you completely free of dizziness between attacks? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any warning that the attack is about to start?
If yes, what? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is the dizziness provoked by a specific head/body movement?
If yes, what direction? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is the dizziness better or worse at any particular time of the day?
If yes, when? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you know of anything that will stop your dizziness or make it better?
If yes, what? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you know of anything that will make your dizziness worse?
If yes, what? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you know of anything that will precipitate an attack?
If yes, what? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 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 | |
| <input type="checkbox"/> | <input type="checkbox"/> | Lightheadedness |
| <input type="checkbox"/> | <input type="checkbox"/> | A swimming sensation in the head |
| <input type="checkbox"/> | <input type="checkbox"/> | A sensation that you could black out or lose consciousness |
| <input type="checkbox"/> | <input type="checkbox"/> | Objects are spinning or turning around you |
| <input type="checkbox"/> | <input type="checkbox"/> | An internal spinning sensation, with objects around you remaining stationary |
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea or vomiting |
| <input type="checkbox"/> | <input type="checkbox"/> | 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 | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Double vision? | Constant In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Blurred vision or blindness? | Constant In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Spots before your eyes? | Constant In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness in face, arms, or legs? | Constant In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Weakness in arms or legs? | Constant In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Confusion or loss of consciousness? | Constant In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty swallowing? | Constant In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Tingling in the face or around the mouth? | Constant In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty speaking? | Constant In Episodes |

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

- | | | | | | |
|--------------------------|--------------------------|---|----------|-----------|------|
| YES | NO | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty hearing? | Left Ear | Right Ear | Both |
| | | If yes, when did this start? _____ | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Does your hearing change with your other symptoms? | Left Ear | Right Ear | Both |
| <input type="checkbox"/> | <input type="checkbox"/> | Noise in your ears or head? | Left Ear | Right Ear | Both |
| | | If yes, does the noise change with your symptoms? _____ | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Fullness, pressure, or stuffiness in your ears? | Left Ear | Right Ear | Both |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in your ears? | Left Ear | Right Ear | Both |
| <input type="checkbox"/> | <input type="checkbox"/> | Discharge from your ears? | Left Ear | Right Ear | Both |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had surgery on your ears? | Left Ear | Right Ear | Both |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had your hearing evaluated? | | | |
| | | If yes, When? _____ By whom? _____ | | | |