

Patient Questionnaire

PATIENT NAME: _____

DATE: _____

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? _____

1. 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

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you experience motion, air or sea sickness? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did you have motion sickness as a child? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a family history of motion sickness? <input type="checkbox"/> Parent <input type="checkbox"/> Sibling <input type="checkbox"/> Child |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have migraine headaches? |
| <input type="checkbox"/> | <input type="checkbox"/> | Were you exposed to any solvents, chemicals, etc.? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever fallen? How many times? _____ |
| | | Where? _____ <input type="checkbox"/> Inside the home <input type="checkbox"/> Outside the home |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you afraid of falling? |

2. 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 (3).

YES

NO

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | My dizziness is constant? If you answered yes, please go to section 3. |
| <input type="checkbox"/> | <input type="checkbox"/> | If in attacks, 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? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is the dizziness provoked by head/body movement? If so, which direction? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is the dizziness worse at any particular time of the day? |
| | | If so, when? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you know of anything that will stop your dizziness or make it better? |
| | | What? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you know of anything that will make your dizziness worse? |
| | | What? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you know of anything that will precipitate an attack? |
| | | What? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you know any possible cause of your dizziness? |
| | | What? _____ |

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3. 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?

4. 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? 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

5. 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