ALBUQUERQUE
HEARING AND BALANCE

Balance Questionnaire

Name: _____ Date of Birth: _____

ENT physician: _____ Date of ENT Appointment: _____

Balance disorders can occur with a variety of symptoms. Please take a few minutes to answer these questions regarding your symptoms and health history. Answer the questions to the best of your ability.

When did you feel dizzy for the first time? _____
How long did it last? _____
How many episodes have you had since? _____
Describe the sensations you are experiencing _____
_____
_____
_____

Please answer the following questions:

YES	NO	
☐	☐	Do you experience motion sickness, air sickness, car sickness, or seasickness?
☐	☐	Do you get headaches or migraines? How often? _____
☐	☐	Does anyone in your family have migraines? Who:_____
☐	☐	Were you exposed to any solvents or chemicals?
☐	☐	Have you had a head or neck injury? If so, please describe: _____
		_____

Do you or a family member have any of the following medical conditions?

You	Family	
☐	☐	Cardiovascular disease, type _____
☐	☐	Cancer, type _____
☐	☐	Autoimmune disorder, type _____
☐	☐	Diabetes
☐	☐	Kidney disorder
☐	☐	Depression
☐	☐	Anxiety
☐	☐	Memory loss
☐	☐	Other: _____

Please answer the following questions about your ***hearing*:

YES	NO	
☐	☐	Do you have difficulty hearing? If so, please circle which ear: Left Right Both
☐	☐	Do you have ringing, buzzing or noise in your ears? If so, please circle which ear: Left Right Both
☐	☐	Do you have fullness or stuffiness in your ears? If so, please circle which ear: Left Right Both
☐	☐	Have you ever had ear surgery? If so, please circle which ear: Left Right Both

Please answer the following questions about your ***dizziness*:

YES	NO	
☐	☐	Is your dizziness continuous? *(If you answered yes, please go to the next section)*
☐	☐	Does anything you do bring on an attack or episode? If yes, describe:_____
☐	☐	Do you have any warning that the attack is about to start? If so, what? _____ How often do episodes occur? _____ When was your most recent episode? _____
☐	☐	Does your hearing change during episodes?
☐	☐	Are you free from dizziness between episodes?

Please go into more detail about your dizziness:

YES	NO	
☐	☐	Does anything make your dizziness worse? If yes, describe:_____
☐	☐	Does anything make your dizziness better? If yes, describe:_____
☐	☐	Do you know any possible cause of your dizziness? If yes, describe:_____
☐	☐	Did your symptoms start after an illness or injury?
☐	☐	Have you fallen as a result of your dizziness?
☐	☐	Are you afraid of falling?

Do you experience any of the following sensations *when you are dizzy*?
Please read through the entire section before selecting answers.

YES	NO	
☐	☐	Light headedness?
☐	☐	Pressure in your head?
☐	☐	Swimming sensation in your head?
☐	☐	Objects spinning or turning around you?
☐	☐	Sensation that you are spinning while objects are stationary?
☐	☐	Nausea or vomiting?
☐	☐	Loss of balance when walking?
☐	☐	Trouble walking in the dark?
☐	☐	Blurred or spotty or double vision?
☐	☐	Bright lights bother you?
☐	☐	Loud noises hurt your ears?
☐	☐	Numbness, weakness, or tingling in the arms, legs, or face?
☐	☐	Blacking out or loss of consciousness?
☐	☐	Confusion?
☐	☐	Difficulty swallowing?
☐	☐	Difficulty speaking?

How often do you consume alcohol? _____

Please list or attach a list of ***all medications, vitamins, and supplements*** that you take regularly:

Name	Dose	How taken (Tablets, drops, etc)	How often
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have anything else to tell us about your particular symptoms which we have not asked you on this questionnaire?

_____

_____

_____