ALBUQUERQUE
HEARING AND BALANCE

Balance Questionnaire

Name: _____

Date: _____

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 your problem first occur? _____

How long did it last? _____

How many episodes have you had? _____

Describe what it feels like when you have an episode: _____

_____

Please answer the following questions:

YES	NO	
☐	☐	Have you ever experienced motion sickness, air sickness, or seasickness?
☐	☐	Do you have frequent headaches or migraines?
☐	☐	Does anyone in your family have migraine headaches? Who:_____
☐	☐	Were you exposed to any solvents or chemicals?
☐	☐	Have you had a neck injury?
☐	☐	Have you had a head injury?
☐	☐	Have you fallen as a result of your dizziness?

☐ ☐ Are you afraid of falling?

Please answer the following questions about your dizziness:

YES NO

☐ ☐ Is your dizziness constant? *(if you answered yes, please go to the next section)*

☐ ☐ Do you have any warning that the attack is about to start?

☐ ☐ Is the dizziness provoked by head or body movements?

Please go into more detail about your episodes:

YES NO

☐ ☐ Does anything make your dizziness worse?

If yes, describe:_____

☐ ☐ Does anything make your dizziness better?

If yes, describe:_____

☐ ☐ Does anything you do bring on an attack or episode?

If yes, describe:_____

☐ ☐ Do you know any possible cause of your dizziness?

If yes, describe:_____

Do you experience any of the following sensations when dizzy?

YES NO

☐ ☐ Light headedness?

☐ ☐ Pressure in your head?

☐ ☐ Swimming sensation in your head?

☐ ☐ Nausea or vomiting?

☐ ☐ Objects spinning or turning around you?

☐ ☐ Sensation that you are spinning while objects are stationary?

☐ ☐ Loss of balance when walking?

☐ ☐ Trouble walking in the dark?

☐ ☐ Double vision?

☐ ☐ Blurred or spotty vision

☐ ☐ Bright lights bother you?

☐ ☐ Loud noises hurt your ears?

☐ ☐ Numbness or weakness in the arms, legs, or face?

☐ ☐ Blacking out or loss of consciousness?

☐ ☐ Confusion?

☐ ☐ Difficulty swallowing?

☐ ☐ Tingling around the mouth?

☐ ☐ Difficulty speaking?

Please answer the following questions about your hearing:

YES NO

☐ ☐ Does your hearing change when you experience dizziness symptoms?

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

☐ ☐ Do you have drainage from 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

Have you or a family member been diagnosed with any of the following medical conditions?

You Family

☐ ☐ Cardiovasuclar disease, type_____

☐ ☐ Cancer, type _____

☐ ☐ Autoimmune disorder, type_____

☐ ☐ Allergies

☐ ☐ Kidney disorder

☐ ☐ Depression

☐ ☐ Anxiety

☐ ☐ Memory loss

☐ ☐ Other: _____

How often do you consume alcohol? _____

Please list *all medications and supplements* that you take regularly: _____

_____

_____

_____

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