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 or 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 symptoms that we have not asked you on this form?

_____

_____

_____

AHB keeps all personal health information (PHI) in secure electronic files. All PHI paperwork is kept in locked containers, then containers are taken by an AAA NAID certified document destruction service and shredded on an industrial shredder.