

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?

