THE BALANCE LABORATORY QUESTIONNAIRE

Name_____________________________________________Birthdate____/____/____Today’s Date____/____/____

Address__________________________________________City____________________State_______ZIP_________

Phone Number (DAY______________HOME)____________Occupation_____________________Sex (circle):  M  F

MARITAL (circle): Divorced Life Partner Married Separated Single Widowed
ETHNICITY (circle): Hispanic Latino Spanish Other
RACE (circle): American Indian or Alaska Nation Asian Black or African American White Native Hawaiian or Other Pacific

DESCRIBE YOUR DIZZINESS OR DISTURBING SYMPTOMS WITHOUT USING THE WORD “DIZZY”:

________________________________________________________________________________________________________

When did the 1st episode begin? _______________________________________________________

What were you doing at the time? ______________________________________________________

DO CURRENT SYMPTOMS OCCUR IN SPELLS/ATTACKS? (CIRCLE)
(versus symptoms all the time) YES NO

How often? ____________________________________________________________________

How long do they last? ____________________________________________________________________

Are you well between attacks? YES NO

If “NO”, describe____________________________________________________________________

ARE SYMPTOMS BROUGHT ON OR WORSENED BY:

Certain positions or movements (rolling or bending over, tilting back, turning head, etc)? YES NO

If “YES”, describe____________________________________________________________________

Activities, work or exertion (house or yard work, exercise, etc.)? YES NO

If “YES”, describe____________________________________________________________________

Medications? YES NO

If “YES”, describe____________________________________________________________________

Standing rapidly? YES NO

If “YES”, describe____________________________________________________________________

Coughing, blowing nose, bearing down during BM? YES NO

Closing your eyes? YES NO

Emotional stress? YES NO
### ARE SYMPTOMS REDUCED BY:

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being perfectly still?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintaining certain head or body positions?</td>
<td></td>
<td></td>
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<tr>
<td>Medications?</td>
<td></td>
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<tr>
<td>If “YES”, which</td>
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</tbody>
</table>

### ARE SYMPTOMS ASSOCIATED WITH:

<table>
<thead>
<tr>
<th>Question</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spinning sensation?</td>
<td></td>
<td></td>
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<tr>
<td>(circle) RIGHT   LEFT   FORWARD   BACKWARD</td>
<td></td>
<td></td>
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<tr>
<td>Lightheadedness or swimming sensation?</td>
<td></td>
<td></td>
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<tr>
<td>Imbalance?</td>
<td></td>
<td></td>
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<tr>
<td>Staggering or veering to one side when walking?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(circle) RIGHT   LEFT   FORWARD   BACKWARD</td>
<td></td>
<td></td>
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<tr>
<td>Falling?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea or vomiting?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing abnormality?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(circle) RIGHT EAR   LEFT EAR   BOTH EARS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Describe if some of the following apply:</td>
<td></td>
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<tr>
<td>Ringing or noise?</td>
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<tr>
<td>Decline, fluctuation or loss?</td>
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<td></td>
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<tr>
<td>Change in character of hearing?</td>
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<td></td>
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<tr>
<td>Pressure or fullness in ear?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(circle) RIGHT EAR   LEFT EAR   BOTH EARS</td>
<td></td>
<td></td>
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<tr>
<td>Changes in vision?</td>
<td></td>
<td></td>
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<tr>
<td>(circle) BLUR   DOUBLE MOVING   FLASHING LIGHTS</td>
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<td></td>
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<tr>
<td>SHADING/DARKENING   SPOTS or LINES</td>
<td></td>
<td></td>
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<tr>
<td>Headaches or pressure?</td>
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<tr>
<td>If “YES”, describe</td>
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<td></td>
</tr>
<tr>
<td>Are headaches associated with sensitivity to noise or bright light?</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Are headaches associated with unusual visual symptoms?</td>
<td></td>
<td></td>
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<tr>
<td>(circle) BLANK or DARK AREAS   FLASHING LIGHTS or COLORS</td>
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<td></td>
</tr>
<tr>
<td>SPARKLING JAGGED LINES   BLUR   DOUBLE VISION</td>
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<tr>
<td>Do the headaches improve with sleep?</td>
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<tr>
<td>Have you been told you have migraine?</td>
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<tr>
<td>Are the headaches triggered by:</td>
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<tr>
<td>(circle) CERTAIN FOODS   STRESS   CAFFEINE</td>
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<tr>
<td>MENSTRUAL PERIOD   RED WINE</td>
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</table>
Does visual motion bother you
   (i.e., watching TV or movie action, walking in malls or grocery aisles)?  YES  NO

Numbness or weakness of face or limbs?
   If “YES”, describe_____________________________________________________

   YES  NO

DO OTHER SYMPTOMS OCCUR WITH DIZZINESS?

Difficulty speaking?  YES  NO

Difficulty walking?  YES  NO

Weakness?  YES  NO

Sensory loss or change?  YES  NO

Clumsiness or poor coordination?  YES  NO

Fainting or blackouts?  YES  NO

Confusion or memory loss?  YES  NO

Illness that preceded dizziness?  YES  NO

Fever/weight loss?  YES  NO

If any of the above occur WITHOUT dizziness, indicate by placing an “X” in the left margin.

Are there any other events or factors associated with your current problem?
___________________________________________________________________________

PAST MEDICAL HISTORY:

Have you ever had:

Severe neck or head injury?  YES  NO
   If “YES”, describe: ____________________________________________________

Earaches or ear infections, now or in the past?  YES  NO
   If “YES”, describe: ____________________________________________________

Exposure to loud noise?  YES  NO
   If “YES”, describe: ____________________________________________________

Ear, eye or head surgery?  YES  NO
   If “YES”, describe: ____________________________________________________

Illness requiring prolonged medication?  YES  NO
   If “YES”, describe: ____________________________________________________

Long-standing trouble with your eyes or vision?  YES  NO
   If “YES”, describe: ____________________________________________________

Sensitivity to motion sickness (e.g., in car or plane)?  YES  NO

___________________________________________________________________________
MEDICAL HISTORY: Please circle any which apply to you

- Diabetes
- High blood pressure
- Stroke
- Seizures
- Asthma/other lung disease
- Gastro-intestinal disorder
- Thyroid disease
- Heart disease
- Cancer
- Heart attack
- Kidney disorder
- PROBLEMS WITH:
  - Joints/bones
  - Urinary or bowel habits
  - Depression/other mood disorder
  - Skin rash or sun sensitivity

OTHER: __________________________________________________________________________

Allergies (including medications): ________________________________________________
___________________________________________________________________________

FAMILY HISTORY: Please circle any which apply to your family

- Diabetes
- Heart disease
- Hearing loss
- Vision Loss
- Stroke
- Neurologic disease
- Dizzy Spells
- Headaches
- Cancer
- OTHER: __________

CURRENT MEDICATIONS: Name and Dosage

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

PREVIOUS MEDICATIONS: Name and Dosage

________________________________________________________________________

SURGERY: Type and Date

________________________________________________________________________
________________________________________________________________________

HABITS:

Do you smoke? If so, how much? ________________________________

Drink alcohol? How much? ________________________________

Have you had major stress in your life recently? YES NO
If “YES”, describe ____________________________________________

Please list any hearing tests, x-rays, head scans, etc., which you have had:
________________________________________________________________________

Please list other physicians that you have seen for your current problem:
NAME: ____________________________________________________________
PHONE: ____________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________