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 White
Black or African American 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:

Being perfectly still? YES NO

Maintaining certain head or body positions? YES NO

Medications? YES NO
If "YES", which _____

ARE SYMPTOMS ASSOCIATED WITH:

Spinning sensation? YES NO
(circle) RIGHT LEFT FORWARD BACKWARD

Lightheadedness or swimming sensation? YES NO

Imbalance? YES NO

Staggering or veering to one side when walking? YES NO
(circle) RIGHT LEFT FORWARD BACKWARD

Falling? YES NO

Nausea or vomiting? YES NO

Hearing abnormality? YES NO
(circle) RIGHT EAR LEFT EAR BOTH EARS

Describe if some of the following apply:

Ringing or noise? _____

Decline, fluctuation or loss? _____

Change in character of hearing? _____

Pressure or fullness in ear? YES NO
(circle) RIGHT EAR LEFT EAR BOTH EARS

Changes in vision? YES NO
(circle) BLUR DOUBLE MOVING FLASHING LIGHTS
SHADING/DARKENING SPOTS or LINES

Headaches or pressure? YES NO
If "YES", describe_____

Are headaches associated with sensitivity to noise or bright light? YES NO

Are headaches associated with unusual visual symptoms? YES NO
(circle) BLANK or DARK AREAS FLASHING LIGHTS or COLORS
SPARKLING JAGGED LINES BLUR DOUBLE VISION

Do the headaches improve with sleep? YES NO

Have you been told you have migraine? YES NO

Are the headaches triggered by: YES NO
(circle) CERTAIN FOODS STRESS CAFFEINE
MENSTRUAL PERIOD RED WINE

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? YES NO
If "YES", describe_____

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

OTHER:_____

Allergies (including medications): _____
_____

FAMILY HISTORY: Please circle any which apply to your family

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

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:
_____	_____
_____	_____
_____	_____