THE BALANCE LABORATORY QUESTIONNAIRE

Name__________________________________________________________________Today’s Date___/___/____
Address__________________________________________City__________________State___________ZIP_______
Occupation____________________________________Sex___Age____Birthdate___/___/____
Phone Number (DAY)_________________________________(HOME)_________________________________
Marital (circle): Divorced Life Partner Married Separated Single Widowed

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) YES NO
(versus symptoms all the time)
How often? ________________________________________________________________
How long do attacks 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”, which______________________________________________________________

Sitting up or 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

Illness that preceded dizziness? 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:

- Sense of yourself spinning (as on a ride)? [YES, NO]
  
  (circle) RIGHT    LEFT    FORWARD    BACKWARD

- Sense of the visual world moving? [YES, NO]

- Lightheadedness or swimming sensation? [YES, NO]

- Imbalance?
  
  If so, pulled:
  
  (circle) RIGHT    LEFT    RANDOM

- 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

  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?
  
  (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?
  
  (circle) BLANK or DARK AREAS    FLASHING LIGHTS or COLORS    SPARKLING JAGGED LINES    BLUR    DOUBLE VISION

  Are headaches associated with (circle) NAUSEA or VOMITING? [YES, NO]

  Are headaches associated with ‘dizziness’? [YES, NO]
Are the headaches triggered by:

- CERTAIN FOODS
- STRESS
- CAFFEINE
- MENSTRUAL PERIOD
- RED WINE
- CHOCOLATE

Have you been told you have migraine?  
YES NO

Does visual motion bother you
(i.e., watching TV or movie action, walking in malls or grocery aisles)?  
YES NO

Numbness or poor coordination of head or limbs?  
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

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: ______________________________

- 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
<table>
<thead>
<tr>
<th>Problems with:</th>
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<th>Problems with:</th>
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<tbody>
<tr>
<td>Diabetes</td>
<td>Thyroid disease</td>
<td>Joints/bones</td>
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<tr>
<td>High blood pressure</td>
<td>Heart disease</td>
<td>Urinary or bowel habits</td>
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<tr>
<td>Stroke</td>
<td>Cancer</td>
<td>Depression/other mood disorder</td>
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<tr>
<td>Seizures</td>
<td>Heart attack</td>
<td>Skin rash or sun sensitivity</td>
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<td>Asthma/other lung disease</td>
<td>Kidney disorder</td>
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<tr>
<td>Gastro-intestinal disorder</td>
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**Other:**

**Allergies (including medications):**

**Family History:** Please circle any which apply to your family

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<thead>
<tr>
<th>Diabetes</th>
<th>Heart disease</th>
<th>Dizzy Spells</th>
<th>Other:</th>
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<tbody>
<tr>
<td>Hearing loss</td>
<td>Stroke</td>
<td>Neurologic disease</td>
<td></td>
</tr>
<tr>
<td>Vision Loss</td>
<td>Headaches</td>
<td>Cancer</td>
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**Current Medications:** Name and Dosage

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**Previous Medications:** Name and Dosage

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**Surgery:** Type and Date

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**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:

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<th>Name:</th>
<th>Phone:</th>
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