# 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)**
(versus symptoms all the time) YES NO

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? YES NO
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? 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

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

Are headaches associated with 'dizziness'? YES NO

Are the headaches triggered by:
(circle) 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? 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

**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

| | | |
|---|---|---|
| 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: |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |