FYZICAL® Dizziness & Fall Prevention Center

The Ear, Nose, Throat & Plastic Surgery Associates

Dizziness and Balance questionnaire

(Please complete this form prior your first visit)

Date: ______________

Patient: ____________________________ Age: ______

Occupation: ☐ full-time ☐ part-time ☐ not working ☐ retired

Symptoms: Check all that apply:

Dizziness	Spinning/Vertigo	Lightheadedness/Fainting	Rocking/tilting
Visual changes	Headache	Fatigue	Unsteadiness
Falling	Ringing/noise in ears	Fullness in ears	Motion sensitive
Hearing loss	Double vision	Brain fog	Imbalance/Disequilibrium

Describe your current problem:

i. When did your problem start (date)? ________________________________

ii. Was it associated with a related event (e.g. head injury) ? ☐ yes ☐ no

If yes, please explain: ____

iii. Was the onset of your symptoms: ☐ sudden ☐ gradual ☐ overnight ☐ other (describe): ____

iv. Are your symptoms: ☐ constant ☐ variable (i.e. come and go in attacks)

➢ If variable:

a. The spells occur every (# of): _______ hours ________ days __________weeks ___________ months ___________ years.

b. The spells last: ☐< 1 min. ☐1-2 min. ☐3-10 min. ☐11-30 min.☐ ½-1 hr. ☐ 2-6 hrs.☐ 7-24 hrs. ☐ > 24 hrs.

c. Do you have any warning signs that an attack is about to happen? ☐ yes ☐ no

If yes, please describe: ____

d. Are you completely free of symptoms between attacks? ☐ yes ☐ no

v. Do your symptoms occur when changing positions? ☐ yes ☐ no

If yes, check all that apply:

VESTIBULAR DISORDERS ASSOCIATION

√	Symptom	√	Symptom
	Rolling your body to the left		Rolling your body to the right
	Moving from a lying to a sitting position		Looking up with your head back
	Turning head side to side while sitting/standing		Bending over with your head down

vi. Is there anything that makes your symptoms worse? ☐ yes ☐ no
If yes, check all that apply:

√	Symptoms	√	Symptoms
	Moving my head		Physical activity or exercise
	Riding or driving in the car		Large crowds or a busy environment
	Loud sounds		Coughing, blowing the nose, or straining
	Standing up		Eating certain foods
	Time of day		Menstrual periods (if applicable)
	Other:		Other:

vii. Is there anything that makes your symptoms better? ☐yes ☐ no
If yes, please explain:

viii. Do you have difficulty walking in the dark or at dusk? ☐yes ☐ no

ix. When you have symptoms, do you need to support yourself to stand or walk? ☐ yes ☐ no
If yes, how do you support yourself?

____

x. Do you have difficulty walking on uneven surfaces (e.g. grass or gravel) compared with smooth surfaces (e.g. concrete)?
☐ yes ☐no

xi. Have you ever fallen as a result of your current problem? ☐yes ☐ no
If yes, # of falls in the last 6 months_______________________________

xii. Has there been a recent change in your vision, including contacts or glasses? ☐ yes ☐ no

Explain: ____

Past medical history: Please circle all that apply:

Concussion	Hypertension/Hypotension	Ataxia
Seizures	Diabetes/Neuropathy	HA/Migraines
Motor vehicle accident	CABG/CAD/Heart attack/CHF	Asthma/COPD
Stroke/TIA	Cancer	History of infection or blood clot
Multiple sclerosis	Peripheral vascular disease	THR/TKR/Spine surgery
Parkinson's disease	Depression/Panic attacks	Hip/knee/ankle/shoulder/back injury
Glaucoma/macular degeneration	Neck arthritis/surgery	High cholesterol/triglycerides
Fibromyalgia	Chronic fatigue syndrome	Auto immune disease

Other: ______________________________________

Medical Tests: ☐ MRI ☐ MRA ☐ CT ☐ X-Ray ☐ Blood
Other: ______________________________________

Vestibular Tests: ☐VNG ☐ Rotational Chair ☐VAT ☐ CDP ☐VEMP ☐vHIT

Onset Type: ☐ SURGICAL ☐INJURY ☐ INSIDIOUS

Describe any ear related symptoms:

i. Do you have difficulty with hearing? yes no
   If yes, which ear(s): left right both
   When did this start? ______________________
ii. Do you wear hearing aids? ☐ yes ☐ no
   If yes, which ear(s): ☐ left ☐ right ☐ both
iii. Do you experience noise or ringing in your ears? ☐yes ☐ no
   If yes, which ear(s): ☐ left ☐ right ☐both
   - Describe the noise: ☐ ringing ☐ buzzing ☐ other: ________________
   - Does the noise pulsate or is it steady? ☐ steady ☐ pulsate ☐ variable
   - Does anything stop the noise or make it better? ☐ yes ☐ no

     If yes, explain: ___________________________________
iv. Do you have pain, fullness, or pressure in your ears? ☐ yes ☐ no
v. Do your ear symptoms occur at the same time as your dizziness/imbalance symptoms?
   ☐ yes ☐ no

When dizzy or imbalanced, do you experience any of the following:

vi. Lightheadedness or a floating sensation? ☐ yes ☐ no
vii. Objects or your environment turning around you? ☐ yes ☐ no
viii. A sensation that you are turning or spinning while the environment remains stable?
   ☐ yes ☐ no
ix. Nausea or vomiting? ☐ yes ☐ no
x. Tingling of hands, feet or lips? ☐yes ☐ no
xi. When you are walking, do you: ☐veer left? ☐ veer right? ☐ remain in a straight path?

SOCIAL HISTORY/LIFESTYLE:

Please indicate your level of activity currently and prior to developing symptoms:

Current activity level: ☐ inactive ☐ light ☐moderate ☐ vigorous with/without walker/cane

List activities/hobbies:

Prior activity level: : ☐ inactive ☐ light ☐moderate ☐ vigorous with/without walker/cane

List activities/hobbies:

If your activity is light or inactive, what are the major barriers? (check all that apply):

☐ dizziness ☐ imbalance ☐ fear of falling ☐ lack of energy

HABITS:
Please describe your habits in regards to the following substances:

Caffeine: ☐ I do not consume caffeine ☐ I consume caffeine.

- I drink ___(#) cups of _______________ (e.g. coffee) per ☐ day ☐ week ☐ month

Tobacco: ☐ I do not consume tobacco. ☐ I consume tobacco

- I smoke/chew__ (#) _________________of (product) per ☐ day ☐ week ☐ month

Alcohol: ☐ I do not consume alcohol. ☐ I consume alcohol.

- I drink _______(#) glasses of ___________(e.g. wine) per ☐ day ☐ week ☐ month

MEDICATIONS: Please provide us with a list of current medications if not submitted before.

Is there anything else you would like to tell us?

5018 NE 15th Ave · Portland, OR 97211 · fax: (503) 229-8064 · (800) 837-8428 · info@vestibular.org · vestibular.org