CLEARCHOICE
HEARING AND BALANCE

Dizziness and Balance Questionnaire

NAME:_____DATE_____

Do you have any of the following (please off your answers)

( )yes ( )no Dizziness (includes vertigo, light-headedness, woozy)
( )yes ( )no Imbalance or Dysequilibrium (see next page to provide details)
( )yes ( )no Falls
( )yes ( )no Difficulty hearing Indicate which ear right left both
( )yes ( )no Noise in ears Indicate which ear right left both
( )yes ( )no Headaches (see next page to provide details)
( )yes ( )no Neck or shoulder aches or stiffness (see next page to provide details)
( )yes ( )no Ever had motion sickness (see next page to provide details)

Have you ever had any of the following?

( )yes ( )no Head and/or neck injuries? Include dates:_____
( )yes ( )no Ear, Brain, or Neck Surgery? Include dates:_____

Only if you have dizziness, please answer all of the following questions and fill in the blanks.
Describe your dizziness:_____

( )yes ( )no Do things around you appear to be whirling or moving?
( )yes ( )no Do you feel as though you are turning or moving?
( )yes ( )no Is your dizziness a FLOATING SENSATION?
( )yes ( )no Is your dizziness accompanied by DISORIENTATION?
( )yes ( )no Is your dizziness accompanied by difficulty with your BALANCE?
( )yes ( )no Is your dizziness accompanied by NAUSEA?
( )yes ( )no Is your dizziness accompanied by HEADACHE?
( )yes ( )no Is your dizziness accompanied by a HEARING change?
( )yes ( )no Is your dizziness accompanied by NOISES in your EAR?
( )yes ( )no Is your dizziness accompanied by PAIN in your NECK?

When did you first ever have dizziness?_____

How often are you dizzy? ( ) all the time ( ) in episodes ( ) when changing positions

If your dizziness occurs in episodes, how long does an episode last? (check all that apply)
( ) seconds ( ) minutes ( ) hours ( ) days ( ) Other:_____

When were your last 2 episodes of dizziness?_____

Do you have any warning that an episode will occur? ( )yes ( ) no ( ) Specify:_____

Which of the following can make your dizziness worse or can trigger an episode? (check all that apply)

_when you're fatigued
_menstrual period
_rolling over in bed to R to L
_in the car
_bending or stooping over
_when you first wake up
_with a weather change
_moving quickly
_turning your head
_looking up
_at the end of the day
_with stress
_with worry
_watching thing move past you
_coughing or straining

Other specify:_____

Dizziness and Balance Quesitonnaire

Name:_____Date:_____

If you have difficulty with you BALANCE, please answer all of the following questions and fill in the blanks.

When did you first begin to lose your balance?_____
How has you balance been affected? ()Suddenly ()Gradually ()In episodes
Does DIZZINESS accompany your loss of balance? ()Always ()Sometimes ()Never
Do you feel PUSHED or do you VEER when you walk? ()To the Right ()To the Left () Either side

If you have difficulty with you HEARING, please answer all the following questions and fill in the blanks.

When did your hearing first begin to change?_____
How has your hearing changed? ()Suddenly () Gradually () In episodes
If your hearing loss occurs in episodes, how long does a typical episode last?_____
Can NOISES in your ear(s) accompany hearing loss? ()Usually ()Sometimes () Never
Can VERTIGO or DIZZINESS accompany hearing loss? ()Usually ()Sometimes ()Never
Can fullness in your ear(s) accompany hearing loss? ()Usually ()Sometimes () Never

If you have HEADACHES, please answer all of the following questions and fill in the blanks.

How old were you when you had your first headache? ()Young Child ()Teens or 20's () Recently
How often do they happen? _____times ()Daily ()Weekly ()Monthly ()Yearly
How long do they last? _____ ()Seconds ()Minutes ()Hours ()Days ()Weeks
Where do you get them? ()Eyes ()Sinuses ()Forehead ()Temple ()Back of head
Are they ever associated with DIZZINESS? ()Always ()Sometimes ()Never
Are they ever associated with VISUAL CHANGES? ()Always ()Sometimes ()Never
Do you feel SICK or NAUSEATED with them? ()Always ()Sometimes ()Never
Does movement sound or light make them worse? ()Always ()Sometimes ()Never
Are they ever associated with VISUAL ()Always ()Sometimes ()Never
Or lights / black spots before your eyes? ()Always ()Sometimes ()Never

If you have NECK PAIN or NECK STIFFNESS, please answer all the following questions and fill in the blanks.

When did you first begin to have neck problems?_____
Does turning your head seem RESTRICTED? ()None ()Right side ()Left side () Either side
Does PAIN in your neck keep you from falling asleep? ()Always ()Sometimes ()Never
Does DIZZINESS occur when you turn your head? ()Always ()Sometimes ()Never
Does PAIN in your neck accompany your DIZZINESS? ()Always ()Sometimes ()Never

If you ever had MOTION SICKNESS, please mark the situations which have caused you to feel sick:

()Amusement park rides ()On boats in rough water ()On boats in calm water ()Around water
()Riding in the car(front) ()Riding in the car (back) ()Reading in the car
()As a child in parents care ()Motion sickness elswhere (specify)_____

Is there anything else you would like us to know about your dizziness? (specify)_____
_____

Patient Signature:_____

Greece
103 Canal Landing Blvd Ste. 3
Rochester, NY 14626
P: (585)723-3440
F: (585)735-4632

Brighton
1065 Senator Keating Blvd Ste 210
Rochester, NY 14618
P: (585)342-4327
F:(585)735-4632