

DIZZINESS & BALANCE MEDICAL HISTORY QUESTIONNAIRE

Complete this questionnaire and bring it with you when you visit your physician. You may want to reference your previous medical history records and/or ask a friend or family member familiar with your condition to help you.

Patient Name: _____ DOB: _____ Date: _____

DIZZINESS SYMPTOMS

Check all that apply (In the space after each symptom you check, rate the severity of that symptom using a scale of 0-10, with 10 being most severe.)

✓	Symptom	1-10	✓	Symptom	1-10	✓	Symptom	1-10	✓	Symptom	1-10
	Dizziness			Spinning			Lightheadedness			Rocking/tilting	
	Visual changes			Tumbling			Nausea			Unsteadiness	
	Falling			Ringling in ears			Fullness in ears			Fainting	
	Hearing loss			Double vision			Brain fog			Other:	

HISTORY OF PRESENT ILLNESS

1) Describe your current problem:

a. When did your problem start (date)? _____

b. Was the onset of your symptoms: ☐ sudden ☐ gradual ☐ overnight ☐ other

(describe): _____

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

d. If variable:

i. The spells occur every (# of): _____ hours _____ days _____ weeks _____ months
_____ years.

ii. The spells last: ☐ < 1 min. ☐ 1-60 min. ☐ 1-3 hrs. ☐ 3-24 hrs. ☐ 1-3 days

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

i. If yes, check all that apply:

✓	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

f. Is there anything that makes your symptoms worse? ☐ yes ☐ no

i. 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:

- g. Do you have difficulty walking in the dark or at dusk? ☐ yes ☐ no
- h. Do you have difficulty walking on uneven surfaces (e.g. grass or gravel) compared with smooth surfaces (e.g. concrete)? ☐ yes ☐ no
- i. Have you ever fallen as a result of your current problem? ☐ yes ☐ no
- j. Do you have a history of:

✓	Symptom	✓	Symptom	✓	Symptom	✓	Symptom
	Migraines		Seizures		Tumor		Stroke
	MS		Neuropathy		Panic attacks		Congestive heart failure
	Concussion		Depression				

2) Describe any ear related symptoms:

- a. Do you have difficulty with hearing? ☐ yes ☐ no
- i. If yes, which ear(s): ☐ left ☐ right ☐ both
- ii. When did this start? _____
- b. Do you experience noise or ringing in your ears? ☐ yes ☐ no
- i. If yes, which ear(s): ☐ left ☐ right ☐ both
- c. Do you have pain, fullness, or pressure in your ears? ☐ yes ☐ no
- d. Do your ear symptoms occur at the same time as your dizziness/imbalance symptoms?
☐ yes ☐ no

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

- a. Lightheadedness or a floating sensation? ☐ yes ☐ no
- b. Objects or your environment turning around you? ☐ yes ☐ no
- c. A sensation that you are turning or spinning while the environment remains stable?
☐ yes ☐ no
- d. Nausea or vomiting? ☐ yes ☐ no
- e. Tingling of hands, feet or lips? ☐ yes ☐ no
- f. When you are walking, do you: ☐ veer left? ☐ veer right? ☐ remain in a straight path?

DIAGNOSTIC TESTING AND TREATMENT:

- 1) Have you seen other healthcare providers for your current condition? ☐ yes ☐ no
- a. If yes, who: ☐ primary care doctor ☐ ENT/HNS doctor ☐ neurologist ☐ cardiologist
☐ Emergency room doctor ☐ Other: _____
- 2) Have you had any of the following done for this condition elsewhere?

✓	Test/Therapy	When	Where	Results
	ENG/VNG			
	CT Scan			
	MRI			
	Posturography			
	Hearing test			
	Physical therapy			Did it help? <input type="checkbox"/> yes <input type="checkbox"/> no
	Occupational therapy			Did it help? <input type="checkbox"/> yes <input type="checkbox"/> no
	Canalith Repositioning			Did it help? <input type="checkbox"/> yes <input type="checkbox"/> no

Is there anything else that you feel is relevant to your condition?

VESTIBULAR DISORDERS ASSOCIATION