# DIZZINESS & BALANCE DISORDER QUESTIONNAIRE

Total Care ENT

## Medical History

| | | |
|---|---|---|
| Have you ever had this type of testing before? | Yes | No |
| Are you currently taking any medication? | Yes | No |
| Have you been hit in the head or knocked unconscious? | Yes | No |
| Have you had a recent ear Infection? | Yes | No |
| Have you ever had ear surgery? | Yes | No |
| Do you have any neck or back problems? | Yes | No |
| Do you wear glasses or contact lenses? | Yes | No |
| Have you been taking any medications regularly before the dizziness started? | Yes | No |

List _____

Do you have any of the following? (circle)

| | | | |
|---|---|---|---|
| High Blood Pressure | Heart attack | Cancer | Diabetes |
| Low Blood Pressure | Seizures | Migraine | Stroke |

## Characterize your Dizziness:

| | | |
|---|---|---|
| I feel unsteady I feel lightheaded | Yes | No |
| I feel like I am spinning | Yes | No |
| I feel like the room is spinning around me | Yes | No |
| I am able to go on with most activities when I am dizzy | Yes | No |

## Onset and Course of Dizziness:

My dizziness started approximately _____

| | | |
|---|---|---|
| My dizziness started suddenly | Yes | No |
| My dizziness comes In attacks | Yes | No |

How often _____ How long do the attacks last? _____

## Other Factors Concerning Dizziness:

| | | |
|---|---|---|
| Does turning your head or body make your dizziness worse? | Yes | No |
| Does anything make your dizziness better? | Yes | No |

If so, what? _____

## Associated Symptoms:

| | | |
|---|---|---|
| Blackout or loss of consciousness, nausea, or vomiting | Yes | No |
| Deafness or difficulty hearing? | Yes | No |
| Ringing, buzzing, or noises In your ear? | Yes | No |
| Fullness, pain, or pressure in your ears? | Yes | No |

Which ear? _____

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