Oregon Ear, Nose & Throat Center
541-779-7331

Balance Questionnaire

NAME _____ DOB _____ AGE _____

(Check yes or no and fill in the blanks)

When you are dizzy, do you have any of the following sensations?

☐ Yes ☐ No Lightheadedness

☐ Yes ☐ No Swimming sensation in the head

☐ Yes ☐ No Blacking out

☐ Yes ☐ No Loss of consciousness

☐ Yes ☐ No Tendency to fall ☐ Left ☐ Right ☐ Forward ☐ Backward

☐ Yes ☐ No Objects spinning around you

☐ Yes ☐ No You are spinning, while outside objects are stationary

☐ Yes ☐ No Loss of balance when walking

Veer to ☐ Left ☐ Right

☐ Yes ☐ No Headache

☐ Yes ☐ No Nausea or vomiting

☐ Yes ☐ No Pressure in the head

☐ Yes ☐ No Pressure in the ear: ☐ Left ☐ Right ☐ Both

☐ Yes ☐ No My dizziness is constant

☐ Yes ☐ No My dizziness is in attacks

When do the attacks first occur? _____

How often? _____

How long do they last? _____

☐ Yes ☐ No Do you know when the attack is about to start? How?

☐ Yes ☐ No Are you free of dizziness between attacks?

☐ Yes ☐ No Are you dizzy only in certain positions?

If yes, what positions? _____

☐ Yes ☐ No Do you have trouble walking in the dark?

Do you know of anything that will:

☐ Yes ☐ No Start the dizziness?

☐ Yes ☐ No Stop the dizziness?

☐ Yes ☐ No Make the dizziness worse?

☐ Yes ☐ No Were you exposed to fumes, paints, etc. at the onset?

☐ Yes ☐ No Have you ever injured your head?

☐ Yes ☐ No Have you ever been knocked unconscious?

☐ Yes ☐ No Have you ever injured your neck?

☐ Yes ☐ No Was there a change in your medications when the dizziness began?

☐ Yes ☐ No Have you ever had ear surgery?

NAME _____ DOB _____

☐ Yes ☐ No Any difficulty hearing? ☐ Left ☐ Right ☐ Both

When did this start? _____

Is it getting worse? _____

☐ Yes ☐ No Any noise in your ears? _____

Describe the noise:

☐ Yes ☐ No Does this noise change with dizziness?

If yes, how? _____

☐ Yes ☐ No Does anything make it better? _____

☐ Yes ☐ No Any fullness in ears? ☐ Left ☐ Right ☐ Both

☐ Yes ☐ No Does this change when dizzy? _____

☐ Yes ☐ No Pain in ears? ☐ Left ☐ Right ☐ Both

☐ Yes ☐ No Discharge from ears? ☐ Left ☐ Right ☐ Both

Do you ever experience the following?

☐ Yes ☐ No Double vision

☐ Yes ☐ No Numbness in face or extremities

☐ Yes ☐ No Blurred vision or blindness

☐ Yes ☐ No Weakness in arms or legs

☐ Yes ☐ No Clumsiness in arms or legs

☐ Yes ☐ No Confusion or loss of consciousness

☐ Yes ☐ No Speech difficulty

☐ Yes ☐ No Swallowing difficulty

☐ Yes ☐ No Tingling around mouth

☐ Yes ☐ No Spots before eyes

Does the following apply?

☐ Yes ☐ No Dizzy after exertion or exercise

☐ Yes ☐ No New glasses or contacts recently

☐ Yes ☐ No Get upset easily

☐ Yes ☐ No Dizzy after not eating for a long time

☐ Yes ☐ No Dizziness relating to menstrual period

The above information is accurate to the best of my knowledge.

_____ _____

Patient Signature Date

_____ _____

Physician Signature Date

_____

Physician Name (Printed)