Dizziness and Balance Questionnaire

Name_____ Age____ Gender: M F Date_____
Address_____ Your Phone No_____
City/State/Zip_____ Referring Doctor_____

CHIEF COMPLAINTS: (circle all that apply)

Dizziness True vertigo (spinning) Swaying/Tilting Lightheadedness Faintness Floating

Loss of Balance Dysequilibrium Unsteadiness Difficulty walking Headache Nausea

Vomiting Fear of Falling Falling (How many times? _____) Double vision Blurry vision

Shortness of Breath Other _____

Provoked by: **Position**? Yes____ No____ **Head Movement**? Yes____ No____
Explain_____

ONSET: Sudden_____ or Gradual_____
Frequency_____ Duration_____
Constant_____ Recurring_____
Current Problems Began_____ Earlier Problems?_____

HEARING/EARS: Hearing Loss: R L Fullness/pressure: R L Tinnitus/ringing: R L

VISION: Vision problem: R L Glasses: Y N Contacts: Y N
Nature of vision problem_____

TESTS: Head MRI? Yes____ No____ Head CT? Yes____ No____
Results? _____

RELATED HEALTH ISSUES: (circle all that apply)

Hypertension Vascular Disease Heart Disease Stroke Diabetes Neuropathy

Prior Head Injury Whiplash Allergies Sinus Problems Neck Pain Back Pain

Explain_____
Other_____

MEDICATIONS/DRUGS:
Alcohol_____ Caffeine_____ Tobacco_____
Medication for Nerves_____ Sedatives_____
Other_____

OTHER INFORMATION: _____
_____
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