

Rehder Balance & Hearing Clinic, Inc.

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Dizziness Questionnaire

Patient Name: _____ **DOB** _____ **Date:** _____

Please answer these questions to the best of your ability. Having this information is helpful to us in understanding your problem and determining a possible cause of your dizziness or balance problem:

- Have you fallen within the last 12 months? Yes No If yes, how many times? _____
- Do you take a vitamin D supplement? Yes No
- Have you had your eyes tested in the last 12 months? Yes No Any perceived vision changes in the last 12 months? Yes No

1. Briefly describe what you are experiencing without using the word "dizzy": _____

2. "Dizziness" is a generic term that encompasses many symptoms. Which of the following best describes your symptoms?
- Yes No **Vertigo:** The sensation of motion or movement when none is present (i.e.: spinning, turning, tipping, and rocking)
- Yes No **Syncope:** The feeling you are going to black out or lose consciousness
- Yes No **Unsteadiness:** Loss of "sure footedness" or balance when walking
- Yes No **Lightheadedness:** A vague sensation of disorientation

3. When did your symptoms begin? _____ Time of day? _____
What were you doing when it began? _____

How long did the symptoms last? (Circle one) **Seconds Minutes Hours Days Constant**

With your symptoms, do you experience...

- nausea? Yes No
- vomiting? Yes No
- ringing in your ears? Yes No
- hearing Loss? Yes No

4. Do your symptoms come in attacks? (Circle one) **Yes No**

How often do they occur? (Circle one) **Daily Every few days Every few months Every few years**

Yes No Are you symptom free between attacks? If no, what do you experience? _____

***When was your last attack?** _____ Describe it. _____

5. Are your symptoms getting... (Circle one) **Better Worse Same Fluctuating**

6. Yes No Is there anything you can do to bring on your symptoms? What? _____

Ear and Hearing History

1. Yes No I have difficulties hearing. **Both Right Left**

Rate your overall hearing ability:

(no problems) **0 1 2 3 4 5 6 7 8 9 10 (extreme difficulty)**

If Yes, was the hearing loss gradual or sudden? _____

2. Yes No Do you wear hearing aids? **Both Right Left**
3. Yes No I have ringing in my ears. **Both Right Left**
4. Yes No I have pressure / fullness in my ears **Both Right Left**
5. Yes No Have you ever had any ear surgeries? If yes, please describe _____

Patient Name: _____

Date: _____

Medical History

Yes No Heart attack When? _____
 Yes No Cardiac Surgery. When? _____
 Yes No Stroke
 Yes No TIAs
 Yes No Ear surgery or disease. What? _____
 Yes No Diabetes
 Yes No Migraines
 Yes No Seizures
 Yes No Multiple sclerosis
 Yes No Cancer treatment. (Radiation, chemotherapy)
 Yes No Anxiety
 Yes No Depression

Yes No Hip problems. Surgery? _____
 Yes No Knee problems. Surgery? _____
 Yes No Back problems. Surgery? _____
 Yes No Neck problems. Surgery? _____
 Yes No Foot problems? _____
 Yes No Head trauma. When? _____
Yes No Other health conditions? Please list:

Medications: Please list all your current medications (or provide a list), including hormones, birth control pills, vitamins, over-the-counter, etc. Please include the name of the medication, dosage and times per day taken. Medications for dizziness/balance should be listed in the next table.

Name	Dosage	# Times per day

What medications have you taken for your dizziness/balance problems?

Name	Dosage	# Times/day	Did it help?
			Yes No
			Yes No
** Are you Currently taking any medications for dizziness / balance?			Yes No

Previous Medical Tests

Have you had any of the following tests in the past?		When?	Results?
Yes	No	Carotid Artery Doppler Flow Study	
Yes	No	MRI of brain With Contrast? Yes / No	
Yes	No	MRA of brain (blood flow study)	
Yes	No	CT Scan of brain	
Yes	No	Heart testing (EKG, echo, stress test)	
Yes	No	Holter monitor testing for irregular heartbeat	
Yes	No	Complete physical including bloodwork	
Yes	No	Hearing evaluation	
Yes	No	Physical Therapy Evaluation for Balance	

Thank you for taking the time to fully complete this questionnaire. Remember to bring it with you to your appointment.