Rehder Balance & Hearing Clinic, Inc.

1101 N. 27th Street, Suite E
Billings, MT 59101

Phone: (406) 245-6893 or (800) 227-3181
Fax: (406) 245-9954

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	Hip problems. Surgery? _____
Yes	No	Cardiac Surgery. When? _____	Yes	No	Knee problems. Surgery? _____
Yes	No	Stroke	Yes	No	Back problems. Surgery? _____
Yes	No	TIAs	Yes	No	Neck problems. Surgery? _____
Yes	No	Ear surgery or disease. What? _____	Yes	No	Foot problems? _____
Yes	No	Diabetes	Yes	No	Head trauma. When? _____
Yes	No	Migraines	**Yes**	**No**	**Other health conditions? Please list**:
Yes	No	Siezures			_____
Yes	No	Multiple sclerosis			_____
Yes	No	Cancer treatment. (Radiation, chemotherapy)			_____
Yes	No	Anxiety			_____
Yes	No	Depression			_____

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.