Patient Name: ___________________________________

Date: ______________

Past Medical History

Do you have, or have you had, any of the following?

Neurologic

☐ Migraine

☐ Stroke/TIA

If so, when? _____________________________

☐ Parkinson's Disease

☐ Seizures/ Epilepsy

☐ Concussion/Head Injury

If so, when? _____________________________

☐ Multiple Sclerosis

☐ Alzheimer's

☐ Other Neurologic _________________________

Cardiovascular

☐ Heart Attack

If so, when? _____________________________

☐ Pacemaker

☐ Peripheral Arterial Disease

☐ High Blood Pressure

☐ Low Blood Pressure

☐ Other Cardiovascular______________________

Respiratory

☐ Breathing Difficulties

☐ Emphysema/COPD

☐ Asthma

☐ Other Respiratory ________________________

Other Health Issues:

____

____

____

____

Orthopedic

☐ Artificial Joints

If yes, which?____________________________

☐ Arthritis

☐ Back Problems

☐ Back Surgery

If so, when? ____________________________

☐ Neck Problems

☐ Osteoporosis/Osteopenia

☐ Other Orthopedic________________________

Vision

☐ Cataracts

If removed, when?________________________

☐ Glaucoma

☐ Macular Degeneration

☐ Other Vision ____________________________

Other

☐ Cancer

Type: ________________________________

☐ Diabetes

☐ Neuropathy

☐ Depression

☐ Anxiety

☐ Thyroid

☐ Gastrointestinal Problems

☐ Rheumatoid Arthritis

☐ Tobacco Use

If yes, how much?_____________________

☐ Alcohol Use

If yes, how much?_____________________

Continue to next page

Patient Name: ___________________________________

Date: ______________

Please list all of your **current medications and supplements**

Prescription	Dosage	Frequency	Route	Reason

Over the counter	Dosage	Frequency	Route	Reason

Supplements & Vitamins	Dosage	Frequency	Route	Reason

Patient Name: ________________________________

Date: _____________

Patient Questionnaire

Equilibrium disorders may appear with a variety of symptoms. Some individuals may experience dizziness or vertigo while others may have imbalance or unsteadiness. Please spend a few minutes answering the questions regarding your history and symptoms. Answer the questions to the best of your ability but please be assured that how you answer will not affect your evaluation.

How or when did your problem first occur? ____

How long did it last? ____

I. Do you experience any of the following sensations? Please read the entire list first. Then put an 'x' in either t he
first box for YES or the second box for NO to describe your feelings most accurately.

YES NO

□ □ Do you experience motion, air or sea sickness?

□ □ Did you have motion sickness as a child?

□ □ Do you have a family history of motion sickness? parent?____sibling?____child?____

□ □ Do you have migraine headaches?

□ □ Were you exposed to any solvents, chemicals, etc.?

□ □ Have you ever fallen? How many times? ________

Where? ________________ Inside the home? _____ Outside the home? _____

□ □ Are you afraid of falling?

II. If you have dizziness, please check the box for either YES or NO, and fill in the blank spaces. If you do not experience dizziness, please go to the next section (III).

YES NO

□ □ My dizziness is constant? If you answered yes, please go to section III.

□ □ If in attacks, how often? ______________________________________

□ □ Are you completely free of dizziness between attacks?

□ □ Do you have any warning that the attack is about to start?

□ □ Is the dizziness provoked by head/body movement? If so, which direction?____________

□ □ Is the dizziness worse at any particular time of the day?

If so, when? ____

□ □ Do you know of anything that will stop your dizziness or make it better?

What? ____

□ □ …………………………………………………… make your dizziness worse?

What? ____

□ □ …………………………………………………… precipitate an attack?

What? ____

□ □ Do you know any possible cause of your dizziness?

What? ____

Patient Name: ___________________________________

Date: ______________

Page 2: Continuation (*Patient Questionnaire)*

III. Do you experience any of the following sensations? Please read the entire list first then please check the box for either YES or NO to describe your feelings most accurately.

YES	NO	
□	□	Light headedness?
□	□	Swimming sensation in the head?
□	□	Blacking out or loss of consciousness?
□	□	Objects spinning or turning around you?
□	□	Sensation that you are turning or spinning inside, with outside objects remaining stationary?
□	□	Tendency to fall………. to the right or left.
□	□	Tendency to fall………. forward or backward
□	□	Loss of balance when walking….. veering to the right?
□	□	Loss of balance when walking….. veering to the left?
□	□	Do you have trouble walking in the dark?
□	□	Do you have problems turning to one side or the other?
□	□	Nausea or vomiting?
□	□	Pressure in the head?

IV. If you have the sense of being off-balance, is the feeling of being off-balance:

Constant	□ Yes	□ No
Spontaneous	□ Yes	□ No
Induced by motion	□ Yes	□ No
Induced by positional changes	□ Yes	□ No
Worse with fatigue	□ Yes	□ No
Worse in the dark	□ Yes	□ No
Worse outside	□ Yes	□ No
Worse on uneven surfaces	□ Yes	□ No

Does the feeling of off balance occur when you are:

Lying down or moving in bed	□ Yes	□ No
Sitting	□ Yes	□ No
Standing	□ Yes	□ No
Walking	□ Yes	□ No

V. History of Falling

Do you or have you fallen (to the ground)? □ Yes □ No

If yes, please describe: ____

____

How often do you fall? _________________________________

Have you injured yourself from falling? □ Yes □ No

If yes, please describe ____

Do you or have you had "near falls"? □ Yes □ No

Do you stumble, stagger, or side-step while you walk? □ Yes □ No

Do you find yourself drifting to one side when you walk? □ Yes □ No

If yes, to which side do you drift? □ Right □ Left

Greater Buffalo centers for Dizziness & Balance
Specialists in Fall Prevention

VI. Have you ever experienced any of the following symptoms? Please check the box for either YES or NO and circle if Constant or if In Episodes.

YES	NO			
☐	☐	Double vision?	☐ Constant	☐ In Episodes
☐	☐	Blurred vision or blindness?	☐ Constant	☐ In Episodes
☐	☐	Spots before your eyes?	☐ Constant	☐ In Episodes
☐	☐	Numbness of face, arms or legs?	☐ Constant	☐ In Episodes
☐	☐	Weakness in arms or legs?	☐ Constant	☐ In Episodes
☐	☐	Confusion or loss of consciousness?	☐ Constant	☐ In Episodes
☐	☐	Difficulty in swallowing?	☐ Constant	☐ In Episodes
☐	☐	Tingling around the mouth?	☐ Constant	☐ In Episodes
☐	☐	Difficulty speaking?	☐ Constant	☐ In Episodes

VII. Can any of the following make your dizziness worse or start an attack?

Fatigue ☐ Yes ☐ No
Exertion ☐ Yes ☐ No
Hunger ☐ Yes ☐ No
Menstrual period ☐ Yes ☐ No
Stress ☐ Yes ☐ No

Do you have any allergies? ☐ Yes ☐ No

If yes, please list: ____

VIII. Do you have any of the following? Please check the box for either YES or NO and circle the ear involved.

YES NO

☐ ☐ Difficulty in hearing? ☐ Both Ears ☐ Right Ear ☐ Left Ear

When did this start? _________________ Is it getting worse? _____________

Does the hearing change with your symptoms? If so, how? ______________

☐ ☐ Noise in your ears? ☐ Both Ears ☐ Right Ear ☐ Left Ear

Describe the noise? ____

Does the noise change with your symptoms? If so, how? __________________

☐ ☐ Does anything stop the noise or make it better? _________________________

☐ ☐ Fullness or stuffiness in your ears? ☐ Both Ears ☐ Right Ear ☐ Left Ear

Does this change when you are dizzy? ________________________________

☐ ☐ Pain in your ears? ☐ Both Ears ☐ Right Ear ☐ Left Ear

☐ ☐ Discharge from your ears? ☐ Both Ears ☐ Right Ear ☐ Left Ear

Below For office staff only