METROPOLITAN NEUROEAR GROUP
BALANCE CENTER OF MARYLAND

HEARING & BALANCE DISORDERS
FACIAL NERVE DISORDERS
ACOUSTIC NEUROMAS, COCHLEAR IMPLANTS
HEAD & NECK SKULL BASE SURGERY

SANJAY PRASAD, M.D., F.A.C.S.
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www.earsite.com

Name: _____
DOB: _____

DIZZINESS AND BALANCE QUESTIONNAIRE

INSTRUCTIONS: Please answer the following questions to the best of your ability. There is extra space at the end of each section to provide additional information. We realize the form is long; however, when completed carefully, it allows us to devote more time to your specific problem. Please bring this completed questionnaire to your first visit.

I. CHIEF CONCERN/REASON FOR VISIT

Please indicate all the symptoms you are currently experiencing (check all that apply):

□ dizziness □ spinning □ lightheadedness □ rocking/tilting □ visual changes
□ tumbling □ cart wheeling □ unsteadiness □ falling □ ringing in ears
□ fullness in ears □ fainting □ hearing loss □ head injury □ Other:_____
□ Other: _____

In your own words, how would you describe your symptoms?

_____
_____

II. HISTORY OF PRESENT ILLNESS

A. Describe your current problem:

1. When did your problem start (date)? _____

2. Was is associated with a related event? □ yes □ no
   If yes, please explain: _____

3. Was the onset of your symptoms? □ sudden □ gradual □ overnight □ other

4. Since the onset of symptoms, are you? □ getting better □ staying the same □ getting worse

5. Using a 0-10 scale with 10 being the worst, rate the severity of your symptoms:
   at the best times: _____/10 and the worst times: _____/10.

6. Do your symptoms limit your normal activities of daily living? □ yes □ no
   If yes, please describe: _____

7. Are your symptoms: □ constant □ variable/come and go in spells or attacks
   If variable, the spells/attacks occur every # of: _____ hours _____days _____weeks _____months
   The spells last # of: _____ seconds _____minutes _____hours _____days _____months
   Do you have any warning signs that an attack is about to happen? □ yes □ no
   If yes, please describe: _____
   Are you completely free of symptoms between attacks? □ yes □ no

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8. Do your symptoms occur when changing positions? □ yes □ no
   If yes, check all that apply:
   - □ rolling your body to the right
   - □ rolling your body to the left
   - □ moving from a lying to a sitting position
   - □ looking up with your head back
   - □ turning your head side to side while sitting or standing
   - □ bending over with your head down

9. Is there anything that makes your symptoms better? □ yes □ no
   If yes, please describe: _____

10. Is there anything specifically that makes your symptoms worse? □ yes □ no
    If yes, check all that apply:
    - □ moving my head
    - □ physical activity or exercise
    - □ riding or driving in the car
    - □ large crowds or a busy environment
    - □ loud sounds
    - □ coughing, blowing the nose, or straining
    - □ standing up
    - □ eating certain foods
    - □ time of day
    - □ menstrual periods (if applicable)
    - □ other: _____
    - □ other: _____

11. Do you have difficulty walking in the dark or at dusk? □ yes □ no

12. When you have symptoms, do you need to support yourself to stand or walk? □ yes □ no
    If yes, how do you support yourself? _____

13. Do you have difficulty walking on uneven surfaces (i.e. grass or gravel) compared with smooth surfaces (i.e. concrete)? □ yes □ no

14. Have you ever fallen as a result of your current problem? □ yes □ no
    If yes, # of falls within the past year: _____ # of "near" falls: _____
    Do you tend to fall: □ forward □ back □ left □ right □ all directions

15. Do you have a history of migraines? □ yes □ no

16. Has there been a recent change in your vision, including contacts or glasses? □ yes □ no

B. Describe any ear related symptoms:

1. Do you have any difficulty with hearing? □ yes □ no
   If yes, which ear(s): □ left □ right □ both □ when did this start? _____

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2. Do you wear hearing aids? □ yes □ no
   If yes, which ear(s): □ left □ right □ both

3. Do you experience noise or ringing in your ears? □ yes □ no
   If yes, which ear(s): □ left □ right □ both
   Describe the noise: □ ringing □ buzzing □ whooshing □ other: _____
   Does the noise pulsate or is it steady? □ steady □ pulsate □ variable in volume/intensity
   Does anything stop the noise or make it better? □ yes □ no
   If yes, explain: _____

4. Do you have any pain, fullness, or pressure in your ears? □ yes □ no
   If yes, which ear(s): □ left □ right □ both

5. Do your ear symptoms occur at the same time as your dizziness/imbalance symptoms? □ yes □ no

C. When dizzy and/or imbalanced, do you experience any of the following:

1. Lightheadedness or a floating sensation? □ yes □ no

2. Objects or your environment turning around you? □ yes □ no

3. A sensation that you are turning or spinning while the environment remains stable ? □ yes □ no

4. Nausea or vomiting? □ yes □ no

5. Tingling of hands, feet, or lips? □ yes □ no

6. When you are walking, do you?: □ veer left □ veer right □ remain in a straight path

D. Prior relevant medical evaluations, diagnostic testing, and treatment:

1. Have you seen other healthcare providers for your current problem? □ yes □ no
   If yes, who: □ primary care doctor □ ENT □ Neurologist □ Cardiologist □ ER □ other: _____

2. Have you had any of the following done for this condition elsewhere? □ yes □ no
   ENG/VNG: Where: _____ When: _____ Results:_____
   MRI: Where: _____ When: _____ Results:_____
   CT Scan: Where: _____ When: _____ Results:_____
   Hearing Test: Where: _____ When: _____ Results:_____
   Physical Therapy: Where: _____ When: _____ Did it help? □ yes □ no

III. SOCIAL HISTORY/LIFESTYLE

A. Please describe your current work status:

1. Current work status: □ full-time □ part-time □ unemployed □ disabled □ retired

2. Occupation: _____

B. Please indicate your level of activity currently and prior to developing symptoms:

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1. Current Activity Level: □ inactive □ light □ moderate □ vigorous
   List Activities/Hobbies: _____

2. Prior Activity Level: □ inactive □ light □ moderate □ vigorous
   List Activities/Hobbies: _____

3. If your activity level is light or inactive, what are the major barriers? (check all that apply)
   - □ dizziness
   - □ imbalance
   - □ fear of falling
   - □ lack of energy
   - □ other: _____

IV. HABITS

A. Please describe your habits in regards to the following substances:

1. Caffeine
   - □ I do not consume caffeine.
   - □ I consume caffeine. I currently have _____ drinks/day usually of: _____
   - □ I consume caffeine. I currently have _____drinks/week usually of: _____
   - □ I consume caffeine. I currently have _____drinks/month usually of: _____
   - □ I consume caffeine. I currently have _____drinks/year usually of: _____

2. Tobacco
   - □ I do not use tobacco products.
   - □ I currently smoke/chew/other: _____ times/day
   - □ I currently smoke/chew/other: _____times/week
   - □ I currently smoke/chew/other: _____times/month
   - □ I currently smoke/chew/other: _____times/year

3. Alcohol
   - □ I do not consume alcohol.
   - □ I consume alcohol. I have _____ drinks/day usually of: _____
   - □ I consume alcohol. I have _____drinks/week usually of: _____
   - □ I consume alcohol. I have _____drinks/month usually of: _____
   - □ I consume alcohol. I have _____drinks/year usually of: _____

4. Recreational drug use
   - □ I do not use drugs.
   - □ I use _____ How many times/day? _____ for how many years? _____

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