

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.
Diplomate American Board of Otolaryngology
Subspecialty Otolology, Neurotology/Cranial Base Surgery
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:

- When did your problem start (date)? _____
- Was is associated with a related event? yes no
If yes, please explain: _____
- Was the onset of your symptoms? sudden gradual overnight other
- Since the onset of symptoms, are you? getting better staying the same getting worse
- 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.
- Do your symptoms limit your normal activities of daily living? yes no
If yes, please describe: _____
- 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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