



	Blood Pressure	Pulse
Base		
Lying		
Standing		

Patient: \_\_\_\_\_  
Date of birth: \_\_\_\_\_  
Date: \_\_\_\_\_

## Balance \ Dizzy Questionnaire

Check the area below that describes you best....

<p><u>How long have the symptoms been going on?</u> ( ) days ( ) weeks ( ) months ( ) years</p>	<p><u>Have you had falls?</u> ( ) yes ( ) no</p>
<p><u>Description of the dizziness?</u> ( ) feeling of being on a boat ( ) lightheadedness ( ) sensation of whirling or spinning</p>	<p><u>Which way do you fall?</u> ( ) backwards ( ) forward ( ) left ( ) right</p>
<p><u>What were you doing when the first episode occurred?</u> ( ) awakened from sleep ( ) after intravenous antibiotics ( ) following trauma ( ) after a "cold" ( ) while rolling over in bed ( ) while walking ( ) while exercising ( ) while scuba diving ( ) Don't know</p>	<p><u>Questions that are related to my ear or hearing?</u> ( ) recent changes in hearing ( ) hearing worse with episodes ( ) ringing in the ears ( ) fullness in the ears ( ) symptoms with rolling over in bed ( ) childhood ear infections ( ) feel normal between attacks ( ) warning signs before attacks ( ) prior ear surgery</p>
<p><u>What was the date of the last episode?</u> _____</p> <p><u>How long do the episodes last?</u> ( ) Seconds ( ) Minutes ( ) Hours ( ) week(s) ( ) Month(s) ( ) Unknown</p>	<p><u>Questions that are related to my eyes or vision?</u> ( ) double or blurred vision ( ) recently obtained new glasses ( ) have difficulty walking in the dark</p>
<p><u>What makes the symptoms worse?</u> ( ) any motion ( ) change in diet ( ) exercise or straining ( ) getting up quickly ( ) head turning ( ) neck extension ( ) no particular event ( ) riding in a car ( ) rolling over in bed</p>	<p><u>Question that are related to my brain?</u> ( ) headaches ( ) fainting spells ( ) seizures ( ) tingling around the mouth ( ) prior head injury or concussion ( ) Parkinson's disease ( ) speech difficulties ( ) numbness of feet ( ) confusion or memory problems</p>
<p><u>How often do the symptoms occur?</u> ( ) once a day ( ) once a week ( ) once a month ( ) 2 to 3 times a day ( ) 2 to 3 times a week ( ) 2 to 3 times a month ( ) constantly ( ) several times a year ( ) sporadically</p>	<p><u>Questions that are related to my heart?</u> ( ) palpitations or arrhythmia ( ) symptoms with getting up to quickly ( ) symptoms with exercise ( ) chest pain ( ) hyperventilation ( ) nausea or vomiting ( ) surgery on lower legs ( ) weakness of legs ( ) thyroid problems ( ) diabetes ( ) symptoms related to menstruation</p>
<p><u>Any medication changes prior to the onset of Symptoms?</u> ( ) yes ( ) no</p>	<p><u>List recent medication changes:</u> _____ _____</p>