EAR Audiology, Inc.
3525 Del Mar Heights Rd #606
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Dizziness and Imbalance Questionnaire

Name: ________________________________ Date: __________________

When you are dizzy or imbalanced do you experience any of the following sensations? After reading the complete list, check 'Yes' or 'No' for each number to describe your feelings most accurately.

1. Lightheadedness or swimming sensation in the head ☐ Yes ☐ No

2. Blacking out or loss of consciousness ☐ Yes ☐ No

3. Tendency to fall:
   - To the right ☐ Yes ☐ No
   - To the left ☐ Yes ☐ No
   - Forward ☐ Yes ☐ No
   - Backward ☐ Yes ☐ No

4. Objects spinning or turning around you ☐ Yes ☐ No

5. Sensation that you are turning or spinning inside, with outside objects remaining stationary ☐ Yes ☐ No

6. Loss of balance when walking:
   - Veering to the right ☐ Yes ☐ No
   - Veering to the left ☐ Yes ☐ No

7. Headache ☐ Yes ☐ No

8. Nausea or vomiting ☐ Yes ☐ No

9. Pressure in the head ☐ Yes ☐ No

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Please check 'Yes' or 'No'. Answer all questions.

1. My dizziness is:
   - Constant ☐ Yes ☐ No
   - In attacks ☐ Yes ☐ No

2. When did dizziness first occur? ____________________________________
   ____
   ____

3. If it occurs in attacks:
   How often? ____
   How long do they last? __________________________________
   When was last attack? ___________________________________
   Do you have any warning before an attack? ☐ Yes ☐ No
   Do they occur at any particular time of day or night? ☐ Yes ☐ No
   Are you free of dizziness between attacks? ☐ Yes ☐ No

4. Does change of position make you dizzy? ☐ Yes ☐ No

5. Do you have trouble walking in the dark? ☐ Yes ☐ No

6. When you are dizzy, do you need support to stand? ☐ Yes ☐ No

7. Do you know of any possible cause of your dizziness? ________________
   ____
   ____

8. What were you doing when you first noticed the dizziness? ___________
   ____
   ____

9. Do you know of anything that will:
   Stop your dizziness or make it better? ☐ Yes ☐ No
   ____
   Make your dizziness worse? ☐ Yes ☐ No
   ____
   Precipitate an attack? (such as fatigue, exertion, hunger, menstrual period, stress, and/or emotional upset) ☐ Yes ☐ No
   ____

10. Were you exposed to any irritating fumes, paints, etc., at the onset of dizziness? ☐ Yes ☐ No

____

____

11. If you are allergic to any medications, please list: ____________________

____

____

12. If you ever injured your head, were you unconscious? ☐ Yes ☐ No

13. If you take any medications regularly for any reason, please list: _____

____

____

____

____

14. Do you use tobacco in any form? If so, how much? ☐ Yes ☐ No

____

Do you have any of the following symptoms? Please check 'Yes' or 'No' and indicate which ear is involved.

1. Difficulty hearing? ☐ Yes ☐ No
   ☐ Both ears ☐ Right ear ☐ Left ear

2. Noise in your ears? ☐ Yes ☐ No
   ☐ Both ears ☐ Right ear ☐ Left ear
   If so, describe the noise: ______________________________

   ____

   ____

3. Does noise change with dizziness? If so, how? ☐ Yes ☐ No
   ☐ Both ears ☐ Right ear ☐ Left ear

   ____

   ____

   ____

4. Fullness or stuffiness in your ears? ☐ Yes ☐ No
   ☐ Both ears ☐ Right ear ☐ Left ear

5. Pain in your ears? ☐ Yes ☐ No
   ☐ Both ears ☐ Right ear ☐ Left ear

6. Discharge from your ears? ☐ Yes ☐ No
   ☐ Both ears ☐ Right ear ☐ Left ear

Have you experienced any of the following symptoms? Please check 'Yes' or 'No' and whether 'Constant' or in 'Episodes'.

1. Double vision, blurred vision or blindness ☐ Yes ☐ No
   ☐ Constant ☐ Episodes

2. Numbness of face ☐ Yes ☐ No
   ☐ Constant ☐ Episodes

3. Numbness of arms or legs ☐ Yes ☐ No
   ☐ Constant ☐ Episodes

4. Weakness in arms or legs ☐ Yes ☐ No
   ☐ Constant ☐ Episodes

5. Clumsiness of arms or legs ☐ Yes ☐ No
   ☐ Constant ☐ Episodes

6. Confusion or loss of consciousness ☐ Yes ☐ No
   ☐ Constant ☐ Episodes

7. Difficulty with speech ☐ Yes ☐ No
   ☐ Constant ☐ Episodes

8. Difficulty with swallowing ☐ Yes ☐ No
   ☐ Constant ☐ Episodes

9. Pain in the neck or shoulder ☐ Yes ☐ No
   ☐ Constant ☐ Episodes

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