HEARING & BALANCE CENTER OF AUSTIN
AT GREAT HILLS ENT

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VESTIBULAR PATIENT QUESTIONNAIRE

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PATIENT NAME:_____ **DATE:**_____

Patients with equilibrium disorders may have a variety of symptoms. These can include dizziness, vertigo, lightheadedness/imbalance, unsteadiness and falls. Please answer all of the questions below to the best of your ability. We know that some of the questions may be difficult to answer or may not apply, but please respond as accurately as possible.

How or when did your problem first occur?_____

How long did it last?_____

I. Please read each of the following carefully and indicate with an "x" for YES or NO.

YES	NO	
☐	☐	Do you experience motion sickness, air sickness or sea sickness?
☐	☐	Did you experience motion sickness as a child?
☐	☐	Do you have a family history of motion sickness?
☐	☐	Do you experience migraines?
☐	☐	Have you ever been exposed to chemicals, solvents, etc?
☐	☐	Have you ever experienced an injury to the head? When?_____
☐	☐	Have you ever lost consciousness because of an injury to the head?
☐	☐	Have you had a neck or back injury? When?_____
☐	☐	Do you use alcohol? How many drinks/week?_____ How often?_____ Most recent?_____
☐	☐	Do you smoke? How much_____
☐	☐	Are you diabetic?_____ Is your blood pressure low/high?_____

II. This section asks specific questions about your balance. If you are not experiencing problems with your balance, please skip this section and proceed to section III.

YES	NO	
☐	☐	Are you off balance?
☐	☐	Do you have difficulty walking?
☐	☐	Do you have a fear of falling?
☐	☐	Have you fallen? If yes, how many times?_____ When was most recent?_____ Where?_____
☐	☐	Do you have a loss of balance when walking? If yes, do you veer to the right or left?_____
☐	☐	Do you have trouble walking in the dark?_____
☐	☐	Do you currently or have you ever used an assistive device (cane, walker, etc.)?
☐	☐	Have you ever received therapy for your balance? If yes, When?_____Where?_____

(continued) →

III. This section asks specific questions about dizziness/vertigo. If you are not experiencing problems with dizziness or vertigo, please skip this section and proceed to section IV.

YES	NO	
☐	☐	Is your dizziness constant? If you answered yes, please go to section IV.
☐	☐	Does your dizziness occur in attacks?
		If yes, how often?_____
☐	☐	Are you completely free of dizziness between attacks?
☐	☐	Do you have any warning that an attack is about to start?
		If yes, what?_____
☐	☐	Is the dizziness brought on by an specific head or body movement?
		If yes, what?_____
☐	☐	Is the dizziness better or worse during any particular time of day?
		If yes, when?_____
☐	☐	Have you noticed if anything makes the dizziness better?
		If yes, what?_____
☐	☐	Have you noticed if anything makes the dizziness worse?
		If yes, what?_____
☐	☐	Do you know of anything that will cause an attack?
		If yes, what?_____
☐	☐	Do you know any possible cause for your dizziness?
		If yes, what?_____

IV. Do you currently experience any of the following sensations? Please read the list carefully and check the boxes that most accurately describe your feelings. You may check as many as needed.

YES	NO	
☐	☐	Lightheadedness
☐	☐	A "swimming" sensation in the head
☐	☐	A sensation that you could "black out" or lose consciousness
☐	☐	That objects are spinning or moving around you
☐	☐	That you are spinning, with objects around you remaining still
☐	☐	Nausea or vomiting
☐	☐	Pressure in your ears or head

V. Have you ever experienced any of the following situations? Please check the appropriate box and circle either "constant" or "in episodes" if applicable.

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

VI. Do you have any of the following symptoms? Please indicate which ear is involved.

YES	NO				
☐	☐	Difficulty hearing?	Left Ear	Right Ear	Both
		If yes, when did this start?_____			
☐	☐	Does your hearing change with your other symptoms?	Left Ear	Right Ear	Both
☐	☐	Noise in your ears or head?	Left Ear	Right Ear	Both
		If yes, does the noise change with your symptoms:_____			
☐	☐	Fullness, pressure or stuffiness in your ears?	Left Ear	Right Ear	Both
☐	☐	Pain in your ears?	Left Ear	Right Ear	Both
☐	☐	Discharge from your ears?	Left Ear	Right Ear	Both
☐	☐	Have you ever had surgery on your ears?	Left Ear	Right Ear	Both
☐	☐	Have you ever had your hearing evaluated?			
		If yes, when?_____ By Whom?_____			

Please obtain your results prior to your appointment