Oregon Ear, Nose, and Throat Center
Balance Questionnaire

Name_____ Date of Birth_____Age_____

I. When you are "dizzy," do you have any of the following sensations?

□ No □ Yes Lightheadedness
□ No □ Yes Swimming sensation in the head
□ No □ Yes Blacking out
□ No □ Yes Loss of consciousness
□ No □ Yes Tendency to fall?
□Left □Right □Forward □Back
□ No □ Yes Objects spinning around you
□ No □ Yes You are spinning, while outside objects are stationary
□ No □ Yes Loss of balance when walking
Veer to □Left □Right
□ No □ Yes Headache
□ No □ Yes Nausea or vomiting
□ No □ Yes Pressure in the head
□ No □ Yes Pressure in the ear: □Left □Right □Both

II. Check yes or no, and fill in the blanks.

□ No □ Yes My dizziness is constant
□ No □ Yes My dizziness is in attacks
When did the attacks first occur?_____
How often?_____
How long do they last?_____
□ No □ Yes Do you know the attack is about to start? How?
_____
□ No □ Yes Are you free of dizziness between attacks?
□ No □ Yes Are you dizzy only in certain positions?
If yes, what positions?_____
□ No □ Yes Do you have trouble walking in the dark?
Do you know of anything that will:
□ No □ Yes Start the dizziness?_____
□ No □ Yes Stop the dizziness?_____
□ No □ Yes Make the dizziness worse?_____
□ No □ Yes Were you exposed to fumes, paints, etc. at the onset of the dizziness?
□ No □ Yes Did you ever injure your head?
□ No □ Yes Have you been knocked unconscious?
□ No □ Yes Did you ever injure your neck?
□ No □ Yes Was there a change in your medications when the dizziness began?
□ No □ Yes Have you had ear surgery?

III. Check yes or no, and fill in the blanks regarding your ears.

□ No □ Yes Any difficulty hearing? □Left □Right □Both
When did this start?_____
Is it getting worse?_____
□ No □ Yes Any noise in your ears? □Left □Right □Both
Describe the noise_____
□ No □ Yes Does the noise change with dizziness?
If yes, then how?_____
□ No □ Yes Does anything make it better?
□ No □ Yes Any fullness in ears? □Left □Right □Both
□ No □ Yes Does this change when dizzy?
□ No □ Yes Pain in ears? □Left □Right □Both
□ No □ Yes Discharge from ears? □Left □Right □Both

IV. Do you ever experience the following?

□ No □ Yes Double vision
□ No □ Yes Numbness in face or extremities
□ No □ Yes Blurred vision or blindness
□ No □ Yes Weakness in arms or legs
□ No □ Yes Clumsiness in arms or legs
□ No □ Yes Confusion or loss of consciousness
□ No □ Yes Speech difficulty
□ No □ Yes Swallowing difficulty
□ No □ Yes Tingling around mouth
□ No □ Yes Spots before eyes

V. Does the following apply?

□ No □ Yes Dizzy after exertion or exercise
□ No □ Yes New glasses or contacts recently
□ No □ Yes Get upset easily
□ No □ Yes Dizzy after not eating for a long time
□ No □ Yes Dizziness related to menstrual period

The above information is accurate to the best of my knowledge._____ _____
Patient Signature Date

I have reviewed the above information with the patient. _____ _____
Physician Signature Date

_____
Physician Name (Printed