Dizziness/Balance Questionnaire

Name: ______________________________ **Date:** ____________________

1. Which of these best describes your dizziness? Please mark only one.
   - ❑ A sensation of movement of yourself or the room (spinning, tilting, or wave-like movement)
   - ❑ Lightheadedness or feeling that you are going to faint
   - ❑ Loss of balance
   - ❑ Disassociation or disorientation with the world
2. When you are dizzy do you experience any of the following sensations? Please mark all that apply.
   - ❑ Lightheadedness or swimming sensation in the head
   - ❑ Blacking out or loss of consciousness
   - ❑ Tendency to fall
   - ❑ Objects spinning or turning around you
   - ❑ Sensation that you are turning or spinning inside
   - ❑ Loss of balance when walking
   - ❑ Headache
   - ❑ Pressure in the head
   - ❑ Hearing loss or change in hearing
   - ❑Fullness or pressure in the ears
   - ❑ Ringing, roaring, or other noises in your ears
   - ❑ Nausea or vomiting
3. When did the dizziness first occur? ______________________________
4. Is the dizziness CONSTANT or does it come in ATTACKS?

   If in attacks:

   How often do these occur?

   How long do they last?

   When was your last attack?

   Do you have any warning that an attack is coming?

   Are you completely free of dizziness between attacks? ❑ Yes ❑ No
5. Does anything provoke or make the dizziness worse? ______________________________

   ____
6. Does anything make the dizziness better? ______________________________

   ____

7. Is your dizziness provoked or changed by moving into or out of a position? ❑ Yes ❑ No

8. Have you ever been diagnosed with a head or neck injury? ❑ Yes ❑ No

9. Have you been diagnosed with any neurological disease such as migraine, multiple sclerosis, or stroke?

   ❑ Yes ❑ No

   If yes, please explain: ____

   ____

10. Have you ever experienced any of the following symptoms?
    - ❑ Double vision, blurred vision or blindness
    - ❑ Numbness of face
    - ❑ Numbness of arms or legs
    - ❑ Weakness in arms or legs
    - ❑Clumsiness of arms or legs
    - ❑ Confusion or loss of consciousness
    - ❑ Difficulty with speech
    - ❑ Difficulty with swallowing
    - ❑ Pain in the neck or shoulder

Ball State University Speech and Audiology Clinic – Family Medical History Form

Patient: ____________ Date: ______ Birthdate: ________ Sex: ________

Address: ____________ City: ________ State: ______ ZIP: ________

Home Phone: (   ) ________ Other Phone: (   ) ________ Email: ____________

Primary Care Physician: ____________ City: ____________

Maternal Ethnicity of Patient: Paternal Ethnicity of Patient: ________

Person Completing this Form *(if not patient):* ____________ Relation to patient: ____________

Reason for Appointment: ____

Please indicate if the patient or any relatives (including at least 3 generations) currently experience or have experienced the listed symptoms or conditions. Please provide additional information if possible and note which relative (e.g., maternal grandmother) when applicable. Information on family health can be useful in understanding potential causes for hearing, speech or language difficulties or other health issues. While some symptoms (e.g., miscarriages or fainting spells) may seem irrelevant, certain combinations of symptoms may signal an underlying condition that is related to the patient's primary concern.

Otologic and Hearing problems: **Relationship/Comments:**

Patient	Relative		
☐	☐	Hearing Loss Present at Birth, Childhood, or Young Adulthood	________
☐	☐	Hearing Loss, Any Age of Onset	________
☐	☐	Vertigo/Dizziness/Balance problems	________
☐	☐	Other	________

Vision Problems:

Patient	Relative		
☐	☐	Premature and/or Progressive, Significant Vision Loss	________
☐	☐	Night Blindness	________
☐	☐	Tunnel Vision	________

Learning Disabilities/Developmental Delays:

Patient	Relative		
☐	☐	Cognitive Function Impairment (Mental Retardation)	________
☐	☐	Speech/Language Delay	________
☐	☐	Motor Delay	________
☐	☐	Learning Disability of Unknown Cause	________
☐	☐	Autistic Spectrum Disorders	________
☐	☐	Other	________

Neurological or Cardiovascular Concerns:

Patient	Relative		
☐	☐	Seizures	________
☐	☐	Fainting	________
☐	☐	Tremors	________
☐	☐	Heart Defect	________
☐	☐	Heart Attack	________
☐	☐	Irregular Heartbeat	________

Patient	Relative	
☐	☐	Sudden Death (unexplained) ______
☐	☐	SIDS ______

Musculoskeletal

☐	☐	Unusual Stature ______
☐	☐	Craniofacial or Oral Abnormalities ______
☐	☐	Cleft Palate/Lip ______
☐	☐	Ear Anomalies ______
☐	☐	Arthritis ______
☐	☐	Frequent Broken Bones ______

Kidney

☐	☐	Kidney Malformation ______
☐	☐	Kidney Disease ______
☐	☐	Blood in Urine ______

Pigmentation

☐	☐	Heterochromia (eyes of different color or a multi-colored eye) ______
☐	☐	Hair (early graying, white patches) ______
☐	☐	Vitiligo ______
☐	☐	Café au Lait Spots ______

Reproductive/Pregnancy Concerns:

Patient	Relative	
☐	☐	Stillbirth ______
☐	☐	Miscarriage ______
☐	☐	Early Menopause ______
☐	☐	Consanguinity (interfamily relationship) ______
☐	☐	Infertility ______

Endocrine:

Patient	Relative	
☐	☐	Diabetes ______
☐	☐	Thyroid Disorder (enlarged thyroid - goiter) ______

Genetic Disorders & Syndromes:

Patient	Relative	
☐	☐	Stickler Syndrome ______
☐	☐	Usher Syndrome ______
☐	☐	Branchio-oto-renal Syndrome ______
☐	☐	Pendred Syndrome ______
☐	☐	Neurofibromatosis type II ______
☐	☐	Mitochondrial Disorders ______
☐	☐	Alport Syndrome ______
☐	☐	Waardenburg Syndrome ______
☐	☐	Long QT Syndrome/Jervell Lange-Nielsen ______

Genetic Disorders & Syndromes *(continued)*: **Relationship/Comments:**

Patient	Relative		
☐	☐	Pierre-Robin Sequence	____________
☐	☐	Treacher Collins Syndrome	____________
☐	☐	Connexin 26 Deafness	____________
☐	☐	Other Syndromes or Chromosomal Abnormalities	____________

Has a family member ever had an evaluation by a geneticist? ☐ yes ☐ no

Please make any additional comments in the space provided below.

Medications and Supplements Form
Ball State Audiology Clinic

Name: _________________________ Date of Birth: ________________ Phone Number:____________________ Today's Date: _________________

Please fill in all medications you take, whether regularly or as needed. Fill in as many categories as possible. If you already have a medication list that includes all of the information below, please feel free to bring that list to the appointment instead. Information on medications can be useful in understanding potential causes for hearing difficulties or other health issues. While some medications or supplements may seem irrelevant, certain combinations of medications and symptoms may relate to your hearing or balance problem(s).

Name of Medications or Supplements	Dosage	How often you take the medication?	Reason for taking	Date Started

Please list allergies (medication or other): ____
____
____