

## VESTIBULAR QUESTIONNAIRE

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Equilibrium disorders may appear with a variety of symptoms. Some individuals may experience dizziness or vertigo while others may have imbalance or unsteadiness. Please spend a few minutes answering the questions regarding your history and symptoms. Answer the questions to the best of your ability but please be assured that how you answer will not effect your evaluation.

How or when did your problem first occur? \_\_\_\_\_

How long did it last? \_\_\_\_\_

**I. Do you experience any of the following sensations? Please read the entire list first. Then put an 'x' in either the first box for YES or the second box for NO to describe your feelings most accurately.**

**YES NO**

- Do you experience motion sickness, airsickness or seasickness?
- Can you read a map or a book while riding in a car?
- Did you have motion sickness as a child?
- Do you have a family history of motion sickness? parent? \_\_\_\_\_ sibling? \_\_\_\_\_ child? \_\_\_\_\_
- Do you have migraine headaches?  
Are you sensitive to sound when you have a migraine headache?  Y  N
- Do you have a family history of migraine headaches?
- Were you exposed to any solvents, chemicals, ( furniture refinishing, fertilizers) etc.?
- Did you have any injuries to your head? When? \_\_\_\_\_
- If you received a head injury, were you unconscious?
- Have you ever had a neck injury?
- Loss of balance while walking? How often? \_\_\_\_\_
- Have you ever fallen? How many times? \_\_\_\_\_  
Where? \_\_\_\_\_ Inside the home? \_\_\_\_\_ Outside the home? \_\_\_\_\_
- Are you afraid of falling?
- Do you take any medications regularly? (i.e. tranquilizers, oral contraceptives, barbiturates, antibiotics, thyroid) What? \_\_\_\_\_
- Do you use alcohol? How often? \_\_\_\_\_

**II. If you have dizziness, please check the box for either YES or NO, and fill in the blank spaces. If you do not experience dizziness, please go to the next section (III).**

**YES NO**

- My dizziness is constant? If you answered yes, please go to section III.
- If in attacks, how often? \_\_\_\_\_
- Are you completely free of dizziness between attacks?
- Do you have any warning that the attack is about to start?
- Is the dizziness provoked by head/body movement? If so, which direction? \_\_\_\_\_
- Is the dizziness better or worse at any particular time of the day?  
If so, when? \_\_\_\_\_
- Do you know of anything that will stop your dizziness or make it better?  
What? \_\_\_\_\_
- ..... make your dizziness worse?  
What? \_\_\_\_\_
- ..... precipitate an attack?  
What? \_\_\_\_\_
- Do you know any possible cause of your dizziness? What? \_\_\_\_\_

**III. Do you experience any of the following sensations? Please read the entire list first then please check the box for either YES or NO to describe your feelings most accurately.**

- | YES                      | NO                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Light headedness?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Swimming sensation in the head?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Blacking out or loss of consciousness?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Objects spinning or turning around you?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Sensation that you are turning or spinning inside, with outside objects remaining stationary? |
| <input type="checkbox"/> | <input type="checkbox"/> | Tendency to fall..... to the right or left.   |
| <input type="checkbox"/> | <input type="checkbox"/> | ..... forward or backward   |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of balance when walking..... veering to the right?                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | ..... veering to the left?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have trouble walking in the dark or standing in shower w/ eyes closed?                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have problems turning to one side or the other?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have difficulty walking on uneven surfaces, i.e. grass, sand, rocks?                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you get dizzy after exertion or overwork?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you get upset easily?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you get dizzy when you have not eaten for a long time?                                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea or vomiting?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Pressure in the head?   |

**IV. Have you ever experienced any of the following symptoms? Please check the box for either YES or NO and circle if Constant or if In Episodes.**

- | YES                      | NO                       |                                     |          |             |
|--------------------------|--------------------------|-------------------------------------|----------|-------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Double vision?                      | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Blurred vision or blindness?        | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Spots before your eyes?             | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness of face, arms or legs?     | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Weakness in arms or legs?           | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Confusion or loss of consciousness? | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty in swallowing?           | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Tingling around the mouth?          | Constant | In Episodes |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty speaking?                | Constant | In Episodes |

**V. Do you have any of the following symptoms? Please check the box for either YES or NO and circle the ear involved.**

- | YES                      | NO                       |   |                            |           |          |
|--------------------------|--------------------------|---|----------------------------|-----------|----------|
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty in hearing?  | Both Ears                  | Right Ear | Left Ear |
|                          |                          | When did this start? _____                                    | Is it getting worse? _____ |           |          |
|                          |                          | Does the hearing change with your symptoms? If so, how? _____ |                            |           |          |
| <input type="checkbox"/> | <input type="checkbox"/> | Noise in your ears?   | Both Ears                  | Right Ear | Left Ear |
|                          |                          | Describe the noise? _____                                     |                            |           |          |
|                          |                          | Does the noise change with your symptoms? If so, how? _____   |                            |           |          |
| <input type="checkbox"/> | <input type="checkbox"/> | Does anything stop the noise or make it better? _____         |                            |           |          |
| <input type="checkbox"/> | <input type="checkbox"/> | Fullness or stuffiness in your ears?                          | Both Ears                  | Right Ear | Left Ear |
|                          |                          | Does this change when you are dizzy? _____                    |                            |           |          |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain in your ears?  | Both Ears                  | Right Ear | Left Ear |
| <input type="checkbox"/> | <input type="checkbox"/> | Discharge from your ears?                                     | Both Ears                  | Right Ear | Left Ear |

Do you wish to add any additional information?: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_