



PATIENT 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, airsick or seasick?
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?
Were you exposed to any solvents, chemicals, 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?
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?

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	
..	..	Light headedness?
..	..	Swimming sensation in the head?
..	..	Blacking out or loss of consciousness?
..	..	Objects spinning or turning around you?
..	..	Sensation that you are turning or spinning inside, with outside objects remaining stationary?
..	..	Tendency to fall..... to the right or left.
..	..	..... forward or backward
..	..	Loss of balance when walking..... veering to the right?
..	..	..... veering to the left?
..	..	Do you have trouble walking in the dark?
..	..	Do you have problems turning to one side or the other?
..	..	Nausea or vomiting?
..	..	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			
..	..	Double vision?	Constant	In Episodes
..	..	Blurred vision or blindness?	Constant	In Episodes
..	..	Spots before your eyes?	Constant	In Episodes
..	..	Numbness of face, arms or legs?	Constant	In Episodes
..	..	Weakness in arms or legs?	Constant	In Episodes
..	..	Confusion or loss of consciousness?	Constant	In Episodes
..	..	Difficulty in swallowing?	Constant	In Episodes
..	..	Tingling around the mouth?	Constant	In Episodes
..	..	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				
..	..	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? _____			
..	..	Noise in your ears?	Both Ears	Right Ear	Left Ear
		Describe the noise? _____			
		Does the noise change with your symptoms? If so, how? _____			
		Does anything stop the noise or make it better? _____			
..	..	Fullness or stuffiness in your ears?	Both Ears	Right Ear	Left Ear
		Does this change when you are dizzy? _____			
..	..	Pain in your ears?	Both Ears	Right Ear	Left Ear
..	..	Discharge from your ears?	Both Ears	Right Ear	Left Ear



## AUDIOLOGY PATIENT QUESTIONNAIRE

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

Please spend a few minutes answering these questions regarding your history and symptoms. Answer them to the best of your ability, but please be assured that how you answer will not affect your evaluation.

Put an 'X' in either the YES box or the NO box, whichever best describes your feelings most accurately.

Do you have any of the following symptoms?

YES NO

Do you have difficulty in hearing?  Both ears  Right ear  Left ear

When did it start? \_\_\_\_\_ Is it getting worse? \_\_\_\_\_

Do you have noise in your ears (tinnitus)?  Both ears  Right ear  Left ear

Describe the noise \_\_\_\_\_

Does the noise change?

If YES, when does it change? \_\_\_\_\_

If YES, how does it change? \_\_\_\_\_

Does anything stop the noise or make it better? \_\_\_\_\_

Do you feel fullness or stuffiness in your ears?  Both ears  Right  Left

Do you have pain in your ears?  Both ears  Right  Left

Do you have discharge from your ears?  Both ears  Right  Left

Have you ever been exposed to loud noise?

If yes, explain \_\_\_\_\_

Do you wear hearing aids?  Both ears  Right  Left

If YES, Do you feel your hearing aids help you hear better?  Yes  No

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**Please check yes, *sometimes*, or no for each of the following items. Do not skip a question if you avoid a situation because of a hearing problem. If you use a hearing aid, please answer the way you hear without the aid.**

		Yes 4	Sometimes 2	No 0
E-1	Does a hearing problem cause you to feel embarrassed when you meet new people?.....	_____	_____	_____
E-2	Does a hearing problem cause you to feel frustrated when talking to members of your family? .....	_____	_____	_____
S-3	Do you have difficulty hearing when someone speaks in a whisper?.....	_____	_____	_____
E-4	Do you feel handicapped by a hearing problem?.....	_____	_____	_____
S-5	Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?.....	_____	_____	_____
S-6	Does a hearing problem cause you to attend religious services less often than you would like? .....	_____	_____	_____
E-7	Does a hearing problem cause you to have arguments with family members?.....	_____	_____	_____
S-8	Does a hearing problem cause you difficulty when listening to radio or television?.....	_____	_____	_____
E-9	Do you feel that any hearing difficulty limits or hampers your personal or social life? .....	_____	_____	_____
S-10	Does a hearing problem cause you difficulty when in a restaurant with relatives or friends? .....	_____	_____	_____

*Do not write below this line.*

**TOTAL SCORE:** \_\_\_\_\_      **E -TOTAL:** \_\_\_\_\_      **S -TOTAL** \_\_\_\_\_