THE UNIVERSITY OF ARIZONA
MEDICAL CENTER
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3 3 0 3

MEDICAL RECORD#

DOB

NAME

VISIT#

Abraham Jacob, M.D.
Department of Surgery/Division of Otolaryngology
Otology, Neurotology, and Cranial Base Surgery

BALANCE DISORDERS QUESTIONNAIRE

Please check any of the descriptions below that best describe your balance problems:

☐ Movement/spinning of environment ☐ Motion sensitivity ☐ Lightheadedness
☐ Falling to the ground ☐ Unsteadiness ☐ Dizzy sensation in head

Add any additional description here: _____
When did your symptoms first begin? _____
Are the symptoms constant or do they come in spells? _____
If your symptoms come in spells, how long do the spells last?
☐ Seconds ☐ Minutes ☐ Hours ☐ Days ☐ Other: _____

Does any particular head or body movement bring on the symptoms? ☐ Yes ☐ No
If yes, what kind of movement? _____
Do you have any nausea or vomiting with these symptoms? ☐ Yes ☐ No

PLEASE CHECK YOUR RESPONSE:

Do you have hearing loss?	☐ No	☐ Yes:	☐ right ear	☐ left ear	☐ both
Do you have any ear noise?	☐ No	☐ Yes:	☐ right ear	☐ left ear	☐ both
Do you have ear pressure?	☐ No	☐ Yes:	☐ right ear	☐ left ear	☐ both
Have you ever had any ear surgery?	☐ No	☐ Yes:	☐ right ear	☐ left ear	☐ both

Please list any medications tried in the past or that you are currently taking for these symptoms:

_____

_____

Have you had formal balance testing (ENG) previously?	☐ Yes	☐ No
Are you under a doctor's care for back or neck problems?	☐ Yes	☐ No
Have you ever received IV antibiotics for a life threatening infection?	☐ Yes	☐ No
Do you have any eye disorder besides wearing glasses?	☐ Yes	☐ No

If you answer "yes" to any of the 4 questions above, please explain: _____

_____

_____

Reviewed by:_____ Date: _____ Military Time: _____