BALANCE DISORDERS QUESTIONNAIRE

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

- Movement/spinning of environment
- Falling to the ground
- Lightheadedness
- Motion sensitivity
- 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: ________

MR-3303 (10/12) TAB - Assessment