

Family Audiology Associates, Inc.
Phone: 419-584-2255 or 419-394-3335
VESTIBULAR PATIENT QUESTIONNAIRE

Patient Name: _____ Date: _____

Does your Medical History include:

YES NO

- Headaches-Chronic or Migraine
- Fatigue
- Difficulty in hearing
- Wear eyeglasses or contacts
- Sinus problems
- Allergies

 If yes, please list:

- Back pain
- Neck pain or whiplash
- Head injury
- Heart attack
- Stroke
- Vascular disease
- Heart disease
- High or low blood pressure
- Respiratory problems
- Diabetes
- Surgery

 If yes, please list the type of surgery and the date.

- Currently taking medication. If yes, please list.

Have you ever experienced any of the following?

YES NO

- Ringing in your ears
- Fullness in your ears
- Pain in your ears
- Drainage from you ears

YES NO

- Double vision
- Blurred vision or blindness
- Problems with tears
- Weakness in arms or legs
- Feeling of pressure in your head
- Numbness or tingling in face or extremities
- Confusion or loss of consciousness
- Difficulty swallowing
- Problems with taste

Please read entire list first, and then check yes or no if you experience:

YES NO

- Black outs
- Light headed or floating sensation
- Feel like you are spinning
- Feel like the room is spinning
- Loss of balance when walking and veer to the left
- Loss of balance when walking and veer to the right
- Tendency to fall to the left
- Tendency to fall to the right
- Tendency to fall backward
- Tendency to fall forward
- Difficulty walking in the dark
- Constant dizziness
When did the dizziness first occur? _____
- Dizziness occurs in episodes or attacks
If yes, how often? _____
- Do you have any warning that the attack is about to start?
- The dizziness only occurs in certain positions
If yes, please explain _____
- Do you know of anything that will stop your dizziness or make it better?
If yes, please explain _____
- Do you know of anything that will make your dizziness worse?
If yes, please explain _____
- Do you know of anything that will start the dizziness?
If yes, please explain _____

Please check yes or no.

YES NO

- Do you know or suspect what may have caused you dizziness?
If yes, please explain _____
- Were you ever exposed to any irritating fumes, paints, etc., prior to the onset of dizziness.
If yes, please explain _____
- Do you smoke, consume alcohol, or caffeine?
Circle one or all that apply. Smoke Alcohol Caffeine
- Did you get new glasses or contacts recently?