ROCKY MOUNTAIN
HEARING & BALANCE

# BALANCE HISTORY FORM

Name: _____ DOB: _____ Sex: ____ Date: _____

1. Please indicate any symptom or sensation you are experiencing.

   □ Spinning □ Swimming □ Imbalance □ Lightheadedness
   □ Motion Sensation □ Nausea □ Vomiting □ Other: _____

2. When did these symptoms begin?

3. Did your symptoms come on gradually or suddenly?

4. How long do symptoms last?
   □ Seconds □ Seconds to minutes □ Minutes to hours □ Hours to days
   □ Continuous □ Other: _____

5. When do symptoms occur?
   □ Lying down □ Standing up □ Rolling over in bed □ Looking up or down
   □ Head movement □ With Stress □ Straining/sneezing/coughing
   □ Loud sounds □ Other_____

6. How often do attacks occur?

7. Are you free from dizziness between attacks? When was your last episode/attack?

8. Have the symptoms become worse (more frequent or more severe)? Or have they improved? If they have improved when did they start improving?

9. Please check all that seem to be **related to your symptoms:**
   □ Falling to one side □Right/Left
   □ Unsteady constantly
   □ Severe or recurrent headaches
   □ Numbness in face or extremities
   □ Slurred or difficult speech
   □ Blacking out or fainting when dizzy
   □ Fatigue
   □ Trouble walking in the dark
   □ Spots before eyes
   □ Double or blurry vision
   □ Anxiety
   □ Fullness, pressure or ringing in the ears
   □ Weakness or clumsiness in arms, legs
   □ Other_____

10. Check all that apply to your **hearing:**
    □ Difficulty hearing
    How Long: _____
    □ Currently Wear Hearing Aids
    How Long: _____
    □ Ringing
    □ Fullness
    □ Exposure to loud noise Left/Right
    □ Previous ear infections
    □ Change in hearing when dizzy Left/Right
    □ Previous Ear Surgery Left/Right
    When: _____

**PLEASE TURN OVER AND COMPLETE THE REVERSE SIDE**

11. Check those that you feel **may** be associated with your dizziness:

□ Recent change in vision □ Headaches □ Stress
□ Diet (including recent changes □ Overwork or exertion

12. Please check all that apply to **your medical history:**

| | | |
|---|---|---|
| □ Stroke | □ High blood pressure | □ Low blood pressure |
| □ Migraines | □ Severe headaches | □ Family history of migraines |
| □ Light sensitivity | □ Sound sensitivity | □ Tunnel vision |
| □ Blurred or double vision | □ Heart problems | □ Head injury |
| □ Eye surgery | □ Visual problems | □ Neck or back problems |
| □ Frequent motion sickness | □ Depression, anxiety, bipolar | □ Neurological disorders |
| □ Knee or hip replacement | □ Thyroid problems | □ Unexplained weight change |
| □ Diabetes | □ Arthritis | □ Severe infection |
| □ Sinus problems | □ Cancer | □ Kidney problems |
| □ Recent stress | □ Carbon monoxide exposure | □ Other _____ |

13. Please list all **surgeries and approximate dates:**

14. What **other tests** have been done previously (hearing tests, CT scans, MRI, blood work, etc.) due to your current symptoms? What were the results?

15. Have you ever had intravenous antibiotics, radiation therapy, or chemotherapy?

16. Have you experienced falls due to your symptoms? Are you concerned about falling in the future?

17. Current **medications:**

| Name of Medication | Reason for taking (e.g. blood pressure) | How often do you this medication | Recent change in prescription (Yes or No) | Have you taken this medication in the past 48 hours? (Yes or No) |
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18. Do you have anything else to tell us about your particular problem that we haven't asked you on this questionnaire?

_____ _____

Patient's Signature Date