TEXAS HEARING CLINIC

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Balance Assessment: Patient Questionnaire

Patient Name: _____ DOB: _____ Date: _____

1. **Describe your symptoms**: _____

_____

_____

2. **Hearing and Health History:**

Have you had a hearing evaluation? ○ Yes ○ No

Do you have a hearing loss? ○ Yes ○ No

If yes, when did it begin? _____

Do you know what caused your hearing loss? _____

Is it ○ Sudden ○ Gradual ○ Fluctuating

Do you have a better ear? ○ Left ○ Right

Do you wear hearing instruments? ○ Both ears ○ Right ear ○ Left ear ○ None

Do you hear ringing in your ears? ○ Yes ○ No

If yes, describe the sound: _____

Is the sound distressing to you? ○ Yes ○ No

Do you feel fullness in the ears? ○ Yes ○ No

Have you had ear infections or middle ear infections? ○ Yes ○ No

If yes, what treatments were used? _____

Does anyone in your family have hearing loss? ○ Yes ○ No

Have you worked around hazardous noise? ○ Yes ○ No

History of the following conditions:

○ Ear surgery	○ Migraines	○ Head injury/unconsciousness	○ Vision problems
○ Cleft palate	○ Arthritis	○ Kidney disease or infection	○ Fainting spells
○ Mumps	○ Scarlet fever	○ Patches of different colored skin	○ Diabetes
○ Measles	○ Allergies	○ Bones that break easily	○ High blood pressure
○ Cancer	○ Meningitis	○ Learning impairment	○ Heart disease or defect
○ Alcohol use_____/week		○ Tobacco use	○ Other: _____

3. **Balance History:**

When did the symptoms first occur? _____

Is your dizziness: ○ Constant ○ Periodic

If periodic, how often do the attacks occur? _____

How long do they last? _____

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Do you have a warning that it is about to occur? ○ Yes ○ No

If yes, what leads to dizziness?_____

Are you free of dizziness between attacks? ○ Yes ○ No

Does the dizziness occur only in certain positions? ○ Yes ○ No

Do you know if something stops or alleviates your dizziness?_____

Do you know something that makes it worse?_____

Do you experience any of the following sensations when experiencing dizzy symptoms?

○ Lightheadedness ○ Blacking out ○ Swimming sensation in the head

○ Nausea or Vomiting ○ Pressure in the head ○ Objects spin or turn around you

○ You are spinning while outside objects remain stationary ○ Headache

○ Loss of consciousness

Loss of balance while walking? ○ Veer to the right ○ Veer to the left

Tendency to fall: ○ Right ○ Left ○ Backward ○ Forward