

Dizziness/Balance History Form
Audiology Department
Braintree Rehabilitation Hospital

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Chief Complaint:

1. How would you describe the sensation that you are feeling? _____

Chronology:

1. Onset of dizziness: _____
2. Is your dizziness constant or does it occur in attacks? _____
3. If episodic, how often are the attacks and what is the duration of the attacks?

4. What are the dates of your attacks? _____

5. Are you free of dizziness between the attacks and do you have any warning before an attack? _____
6. Does your dizziness begin when you awaken in the morning? _____
7. Do you have any history of morning sickness? _____

Preceding Events, Triggers, and Pattern of Dizziness:

1. Is there a specific event that preceded your dizziness? (flu, physical exertion, swimming or diving, etc.) _____

2. What do you think brings on an attack? _____

3. Does a change in position make you feel dizzy? _____ If so, what position provokes an attack? _____

**CASE HISTORY
FOR
BALANCE DISORDERS**

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4. When you are having an attack, do you feel that you are falling?
To the Right_____ Left_____ Forward_____ Backward_____

5. When you are dizzy, do you need to support yourself when you are standing?

6. Do you ever have a sensation of objects spinning or turning around you, or that you are turning or spinning inside?

7. Do you feel that you have “loss of balance” when walking?

8. Is there anything that will stop or make your dizziness feel better?

9. Do you have any nausea or vomiting during these attacks?

Associated Symptoms:

Do you have any of the following symptoms?

- A. Otologic:
 1. Aural fullness or stuffiness?_____
 2. Noise in your ears?_____
 3. Description of the noise?_____
 4. Does this noise increase before or after your attacks?_____
 5. Any discharge or otalgia?_____
 6. Any history of ear infections?_____
 7. Any otologic surgery?_____
 8. Do you have any difficulty with your hearing? If so which ear and for how long?_____
 9. Does your hearing fluctuate with your attacks?_____

**CASE HISTORY
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B. Ocular:

1. Do you have difficulty walking in the dark? _____
2. Do you have blurred vision, double vision, or see spots before your eyes?

C. Central Nervous System:

1. Have you experienced any numbness of the face, arms, or legs? _____
2. Any weakness in the arms or legs? _____
3. Do you have any difficulty speaking or swallowing? _____
4. Have you ever had any head injuries? _____
Did you lose consciousness? _____
5. Other: _____

Other Related Factors:

1. Do you feel lightheaded when you are dizzy? _____
2. Do you have any swimming sensation in your head? _____
3. Do you ever feel as if you are going to black out when you are dizzy? _____
4. Do you have a headache when you are dizzy? _____
5. Do you have a feeling of pressure in your head? _____
6. Do you feel faint when you are dizzy? _____
7. Do you get dizzy after overworking or exertion? _____
8. Do you get dizzy when you are hungry? _____
9. Do you smoke? _____ Do you drink alcohol? _____
If so, how many drinks do you have in a day? _____ Weekly: _____
10. Do you have high blood pressure? _____
11. Are you taking any medications? _____ Which ones? _____
When was your last dose? _____
12. Any cardiac or other medical issues? _____
13. Any family history of dizziness or balance problems? _____