

OSU BALANCE DISORDERS CLINCL QUESTIONNAIRE

NAME & DATE: _____

NOTICE: PLEASE BE SURE TO REVIEW YOUR TEST INSTRUCTIONS

Which of the following best describes your dizzy symptoms?

a) I see movement/spinning of environment	d) I have fallen
b) I feel spinning inside my head	e) I have unsteadiness when I walk
c) I have lightheadedness	f) I have motion sensitivity

Additional Descriptions: _____

When did this problem first begin? _____

Is your dizziness present continuously or does it come and go in spells? _____

If you do have spells, how long do they last? Seconds Minutes Hours Days

Does any particular head or body movement bring on the symptoms? NO YES

If yes, which ones? a) rolling in bed b) looking up or tilting head back c) bending over
d) sitting up on the side of the bed e) when 1st lying back in bed f) when I first stand up

Do you have any nausea or vomiting? NO YES

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 any 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 you are currently taking or have tried in the past for dizziness:

Do you have a history of headaches, stroke or seizures? NO YES

Did you have car sickness as a child? NO YES

Have you had formal balance testing (ENG/VNG) previously? NO YES

Are you under a doctor's care for back or neck problems? NO YES

Have you ever received IV antibiotics for a life threatening infection? NO YES

Do you have any eye disorder besides wearing glasses? NO YES

*If you think this testing has been scheduled in error, please contact our office at 614-366-3687 prior to your appointment.