New Hampshire Hearing and Balance
655 Portsmouth Ave.
Greenland,NH
603.436-4655

Patient Name:_____**D.O.B**_____**DATE**:_____

Equilibrium disorders may appear with a variety of symptoms. Some individuals may experience dizziness or vertigo, while others have imbalance or unsteadiness. Please spend a few minutes answering the questions regarding your history and symptoms. Answer the questions to the best of your ability but please be assured that how you answer will not effect your evaluation.

How or when did your problem first occur? _____

_____

How long did it last? _____

Date of last physician appointment?_____ Date of next physician's appointment? _____

Do you experience any of the following? Please read the entire list first, and then check either the first box for YES or the second box for NO to describe your feelings most recently.

YES	**NO**	
___	___	Did you have motion sickness as a child?
___	___	Do you have migraine headaches?
___	___	Do you have a family history of migraine headaches?
___	___	Were you exposed to any solvents, chemicals?
___	___	Have you received any injuries to your head? When? _____
___	___	Have you ever had a neck injury?
___	___	Have you ever fallen? How many times? _____
___	___	Were these falls associated with your symptoms of dizziness?
___	___	Are you afraid of falling?
___	___	Do you use alcohol?
___	___	Do you live alone?

If you have dizziness, please check the box for either YES or NO, and fill in the blank spaces. If you do not experience dizziness, please go to the next section.

YES	**NO**	
___	___	My dizziness is constant?
___	___	If in attacks, how often?
___	___	Are you completely free of dizziness between attacks?
___	___	Do you have any warning that an attack is about to start?
___	___	Is the dizziness provoked by head/body movement?
		If so describe. _____
___	___	Do you know of anything that will stop your dizziness or make it better?
		What _____
___	___	Do you know of any possible cause of your dizziness? Describe _____

Do you experience any of the following sensations?

YES	**NO**	
___	___	Lightheadedness?
___	___	Swimming sensation in the head?
___	___	Blacking out or losing consciousness?
___	___	Objects spinning or turning around you?
___	___	Sensation that you are turning or spinning?
___	___	Tendency to fall to the right or left?
___	___	Do you have trouble walking in the dark?
___	___	Nausea or vomiting?

Have you ever experienced any of the following symptoms?

YES	NO	
___	___	Double vision?
___	___	Spots before your eyes?
___	___	Numbness of face, arms, or legs?
___	___	Confusion or loss of consciousness?
___	___	Have you started taking any new medications in the past six months?
		If yes, please list: _____

Did you ever have any of the following symptoms?

YES	NO	
___	___	Difficulty in hearing? Both ears Right ear Left ear
		When did this start?
___	___	Is there any association between your hearing symptoms and your dizziness?
___	___	Do you have any noise in your ears? Describe_____
___	___	Does anything stop the noise or make it better?
___	___	Do you have any fullness or pressure in your ears? Both Right ear Left ear
___	___	Does this change when you are dizzy?
___	___	Pain in your ears?
___	___	Discharge from your ears?

Please list any medications you are presently taking.

Medication	**Taking For:**	**When you first started using.**

Please list any drug allergies:

_____ _____

_____ _____

_____ _____

Other Allergies:

_____ _____