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Balance Patient Information

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**1. When you are dizzy, do you experience any of the following sensations?**

**Yes**

**No**

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Lightheadedness  |
| <input type="checkbox"/> | <input type="checkbox"/> | Swimming sensation in the head                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Objects spinning or turning around you                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of balance when walking (veering to ____right ____left) |
| <input type="checkbox"/> | <input type="checkbox"/> | Tendency to fall ____right ____left ____forward ____backward |
| <input type="checkbox"/> | <input type="checkbox"/> | Blacking out   |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of consciousness  |
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea and/or vomiting                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Headache   |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizzy when turning over in bed.                              |

**2. Dizziness History**

When did your dizziness first occur? \_\_\_\_\_

Do you know of any possible cause of your dizziness? \_\_\_\_\_

How often does your dizziness occur? \_\_\_\_\_

Is your dizziness constant or does it come in attacks? \_\_\_\_\_

How long does a spell of dizziness last? \_\_\_\_\_

**Yes**

**No**

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Were you exposed to any irritating fumes, paints, etc when the dizziness started? |
| <input type="checkbox"/> | <input type="checkbox"/> | Did you ever injure your head?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Can you tell when a spell of dizziness is about to start?                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Does change in position make you dizzy?   |
| <input type="checkbox"/> | <input type="checkbox"/> | When you are dizzy, can you stand unsupported?                                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any allergies?  |

**3. Do you have any of the following symptoms?**

Difficulty hearing \_\_\_\_\_ No \_\_\_\_\_ Both ears \_\_\_\_\_ Right \_\_\_\_\_ Left

Noise in your ears \_\_\_\_\_ No \_\_\_\_\_ Both ears \_\_\_\_\_ Right \_\_\_\_\_ Left

Pain in your ears \_\_\_\_\_ No \_\_\_\_\_ Both ears \_\_\_\_\_ Right \_\_\_\_\_ Left

Fullness or stuffiness in your ears \_\_\_\_\_ No \_\_\_\_\_ Both ears \_\_\_\_\_ Right \_\_\_\_\_ Left

Does this change in any way when you are dizzy \_\_\_\_\_ Yes \_\_\_\_\_ No

Drainage from your ears \_\_\_\_\_ No \_\_\_\_\_ Both ears \_\_\_\_\_ Right \_\_\_\_\_ Left

When? \_\_\_\_\_

**4. Have you experienced any of the following symptoms? If so, are they constant or do they come and go?**

Double/blurred vision or blindness \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Constant \_\_\_\_\_ Episodes

Numbness of face or extremities \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Constant \_\_\_\_\_ Episodes

Weakness of arms or legs \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Constant \_\_\_\_\_ Episodes

Clumsiness of arms or legs \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Constant \_\_\_\_\_ Episodes

Confusion \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Constant \_\_\_\_\_ Episodes

Difficulty swallowing \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Constant \_\_\_\_\_ Episodes

**5. What medications do you take?**

**6. The scale below consists of a number of words that describe different feelings and emotions. Read each item and indicate to what extent you generally feel this way (that is, how you feel on average). Use the following scale to record your answers:**

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
Very slightly or not at all	a little	moderately	quite a bit	extremely

\_\_\_\_\_ interested      \_\_\_\_\_ irritable      \_\_\_\_\_ jittery      \_\_\_\_\_ strong      \_\_\_\_\_ nervous

\_\_\_\_\_ enthusiastic      \_\_\_\_\_ distressed      \_\_\_\_\_ alert      \_\_\_\_\_ active      \_\_\_\_\_ excited

\_\_\_\_\_ ashamed      \_\_\_\_\_ afraid      \_\_\_\_\_ upset      \_\_\_\_\_ inspired      \_\_\_\_\_ hostile

\_\_\_\_\_ guilty      \_\_\_\_\_ determined      \_\_\_\_\_ proud      \_\_\_\_\_ scared      \_\_\_\_\_ attentive

## Dizziness Inventory

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer "Yes," "No," or "Sometimes" to each question. *Answer each question as it pertains to your dizziness or unsteadiness only.*

	<b>Yes</b>	<b>No</b>	<b>Sometimes</b>
P1. Does looking up increase your problem?	_____	_____	_____
E2. Because of your problem, do you feel frustrated?	_____	_____	_____
F3. Because of your problem, do you restrict your travel for business or recreation?	_____	_____	_____
P4. Does walking down the aisle of a supermarket increase your problem?	_____	_____	_____
F5. Because of your problem, do you have difficulty getting into or out of bed?	_____	_____	_____
F6. Does your problem significantly restrict your participation in social activities such as going out to dinner, the movies, dancing, or to parties?	_____	_____	_____
F7. Because of your problem, do you have difficulty reading?	_____	_____	_____
P8. Does performing more ambitious activities like sports, dancing, or household chores such as sweeping or putting away dishes increase your problem?	_____	_____	_____
E9. Because of your problem, are you afraid to leave your home without having someone accompany you?	_____	_____	_____
E10. Because of your problem, are you embarrassed in front of others?	_____	_____	_____
P11. Do quick movements of your head increase your problem?	_____	_____	_____
F12. Because of your problem, do you avoid heights?	_____	_____	_____
P13. Does turning over in bed increase your problem?	_____	_____	_____
F14. Because of your problem, is it difficult for you to do strenuous housework or yardwork?	_____	_____	_____
E15. Because of your problem, are you afraid people may think you are intoxicated?	_____	_____	_____
F16. Because of your problem is it difficult for you to walk by yourself?	_____	_____	_____
P17. Does walking down a sidewalk increase your problem?	_____	_____	_____
E18. Because of your problem is it difficult for you to concentrate?	_____	_____	_____
F19. Because of your problem is it difficult for you to walk around your house in the dark?	_____	_____	_____

	<b>Yes</b>	<b>No</b>	<b>Sometimes</b>
E20. Because of your problem, are you afraid to stay home alone?	_____	_____	_____
E21. Because of your problem, do you feel handicapped?	_____	_____	_____
E22. Has your problem placed stress on your relationships with members of your family or with friends?	_____	_____	_____
E23. Because of your problem, are you depressed?	_____	_____	_____
F24. Does your problem interfere with your job or household responsibilities?	_____	_____	_____
P25. Does bending over increase your problem?	_____	_____	_____