ROCKET BALANCE

Center for Dizziness and Imbalance

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☐ First visit
☐ Follow-up
☐ Annual check

DIZZINESS QUESTIONNAIRE

Patient's Name ______________________ Today's Date ____________

Describe the purpose of today's visit ______________________

Describe the first time you felt dizziness and/or imbalance. When did it occur? What else happened?

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Describe the most recent time you felt dizziness and/or imbalance. When did it occur? What else happened?

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Circle Y for Yes or N for No for each of the following statements about your experience with dizziness and/or imbalance.

Y N	It is constant.	Y N	It happens when standing or walking.
Y N	It comes and goes.	Y N	It happens when I move my head.
Y N	It is always there, but some times are worse than others.	Y N	It happens when I bend over or look up.
		Y N	It happens when I get in or out of bed.
		Y N	It happens when I stand up from a chair.
Y N	It lasts a few seconds at a time.		
Y N	It lasts a few minutes at a time.	Y N	It makes me feel nauseous.
Y N	It lasts hours at a time.	Y N	It makes me feel faint.
Y N	It lasts days at a time.	Y N	It makes me vomit.

What can you do to make the dizziness and/or imbalance stop? ______________________

How do you feel between episodes? ______________________

Do you have any co-occuring symptoms?

Y N	Hearing loss	Y N	Ringing in the ears
Y N	Pain or pressure in the ears	Y N	Blurred or doubled vision

How active were you before your problem started?

And, how active are you now?

AROUND THE TIME YOUR DIZZINESS AND/OR IMBALANCE STARTED, DID YOU...

Y N	Experience a cold or virus?	Y N	Had not eaten for an extended period of time?
Y N	Incur an accident or head trauma?	Y N	Experience intense stress or anxiety?
Y N	Lose consciousness?	Y N	Participate in heavy lifting?
Y N	Travel by air or swim underwater?	Y N	Experience a headache or migraine?

Other: ______________________

FALLS HISTORY

Have you fallen in the last year?	Y N	If yes, when was your last fall?	________
Do you worry about falling?	Y N	Do you feel unsteady when standing or walking?	Y N

DIZZINESS HISTORY

	Please check A for Always, S for Sometimes, and N for Never for each question.	**A**	**S**	**N**
1	Does looking up increase your problem?			
2	Because of your problem, do you feel frustrated?			
3	Because of your problem, do you restrict your travel for business or pleasure?			
4	Does walking down the aisle of a grocery store increase your problem?			
5	Because of your problem, do you having difficulty getting out of or into bed?			
6	Does your problem restrict your participation in social activities, like going out to dinner?			
7	Because of your problem, do you have difficulty reading?			
8	Does your problem increase when performing sports activities or household chores?			
9	Because of your problem, are you afraid to leave home without someone with you?			
10	Because of your problem, have you become embarassed in front of others?			
11	Do quick movements of your head increase your problem?			
12	Because of your problem, do you avoid heights?			
13	Does turning over in bed increase your problem?			
14	Because of your problem, is it difficult to do strenuous housework or yardwork?			
15	Because of your problem, are you afraid people will think you are intoxicated?			
16	Because of your problem, is it difficult for you to go for a walk by yourself?			
17	Does walking does a sidewalk increase your problem?			
18	Because of your problem, is it difficult for you to concentrate?			
19	Because of your problem, is it difficult for you to walk around your house in the dark?			
20	Because of your problem, are you afraid to stay at home alone?			
21	Because of your problem, do you feel handicapped?			
22	Has your problem placed stress on relationships with friends and family?			
23	Because of your problem, do you feel depressed?			
24	Does your problem interfere with your job or household responsibilities?			
25	Does bending over increase your problem?			

Are there any other details that you would like to share?

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