



CENTER FOR BALANCE DISORDERS
MEDICAL QUESTIONNAIRE

http://www.bcm.edu/oto/cfbd/
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The Neurosensory Center of Houston
3rd Floor, Room NA315

Name: _____ ID Number: _____ Test Date: _____

A. Have you experienced any of the following symptoms? Please check the appropriate boxes.

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Dizziness? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Imbalance? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Motion Sickness? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Difficulty hearing?..... <input type="checkbox"/> Right ear..... <input type="checkbox"/> Left ear..... <input type="checkbox"/> Both ears |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Noise in your ears? <input type="checkbox"/> Right ear..... <input type="checkbox"/> Left ear..... <input type="checkbox"/> Both ears
Describe the noise _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Fullness or stuffiness in your ears?..... <input type="checkbox"/> Right ear..... <input type="checkbox"/> Left ear..... <input type="checkbox"/> Both ears |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Pain in your ears? <input type="checkbox"/> Right ear..... <input type="checkbox"/> Left ear..... <input type="checkbox"/> Both ears |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Discharge from your ears?..... <input type="checkbox"/> Right ear..... <input type="checkbox"/> Left ear..... <input type="checkbox"/> Both ears |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Perforated eardrum?..... <input type="checkbox"/> Right ear..... <input type="checkbox"/> Left ear..... <input type="checkbox"/> Both ears |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Frequent ear infections? <input type="checkbox"/> Right ear..... <input type="checkbox"/> Left ear..... <input type="checkbox"/> Both ears |

B. If you experience dizziness/imbalance, please answer the following questions.

1. When did the dizziness or imbalance first occur? _____
2. How often do you become dizzy or imbalanced? _____
3. If in spells:
 - a. How long does the spell last? _____
 - b. When was the last spell? _____
 - c. Are you completely free of dizziness between spells? _____
 - d. Is the onset of dizziness sudden or gradual? _____
4. Does change of position make you dizzy or throw you off balance? Yes No
 - a. What position(s)? _____
 - b. What side do you sleep on? _____
5. Did you take a long trip (at least 5 hours travel time) just before the dizziness or imbalance began?
Yes No
6. Do you know of anything that will:
 - a. Stop your dizziness/imbalance or make it better? What? _____
 - b. Make your dizziness/imbalance worse? What? _____
7. Do you know of any possible cause for your dizziness/imbalance? Yes No
If so, what? _____
8. Are you contemplating ear surgery? Yes No
 - a. What procedure? _____
 - b. When? _____
9. Have you ever had surgery on your head and neck region (including the eyes, ears, nose, and throat)?
Yes No
 - a. What type? _____
 - b. When? _____

Please turn page and finish questionnaire.

C. Is your dizziness or imbalance associated with any of the following sensations?

Yes No

- 1. Light-headedness or swimming sensation in the head.
- 2. Blacking out or loss of consciousness.
- 3. Tendency to fall.
- 4. Objects spinning or turning around you.
- 5. Sensation that you are spinning or turning inside, with outside objects remaining stationary.
- 6. Loss of balance when walking: Veering to the right? Veering to the left?
- 7. Headache.
- 8. Nausea or vomiting.
- 9. Pressure in head.
- 10. Additional Comments? _____

D. Have you ever experienced any of the following medical conditions?

Yes No

Yes No

Yes No

- | | | |
|--|---|--|
| <input type="checkbox"/> <input type="checkbox"/> Allergies | <input type="checkbox"/> <input type="checkbox"/> HIV Positive | <input type="checkbox"/> <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> <input type="checkbox"/> Sinus Infections | <input type="checkbox"/> <input type="checkbox"/> Hypertension | <input type="checkbox"/> <input type="checkbox"/> Head Injury |
| <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Heart Disease | <input type="checkbox"/> <input type="checkbox"/> Other Neurological Disorder |
| <input type="checkbox"/> <input type="checkbox"/> Bronchitis | <input type="checkbox"/> <input type="checkbox"/> Stroke | <input type="checkbox"/> <input type="checkbox"/> Muscle, Bone or Joint Injury |
| <input type="checkbox"/> <input type="checkbox"/> Emphysema | <input type="checkbox"/> <input type="checkbox"/> Seizures | <input type="checkbox"/> <input type="checkbox"/> Neck or Back Pain |
| <input type="checkbox"/> <input type="checkbox"/> Eye Problems | <input type="checkbox"/> <input type="checkbox"/> Tremor (shakiness) | <input type="checkbox"/> <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Claustrophobia | <input type="checkbox"/> <input type="checkbox"/> Prosthesis/Implant |
| <input type="checkbox"/> <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> <input type="checkbox"/> Fear of Heights | <input type="checkbox"/> <input type="checkbox"/> Alcohol Dependency |
| <input type="checkbox"/> <input type="checkbox"/> Cancer | <input type="checkbox"/> <input type="checkbox"/> Fear of Open Spaces | <input type="checkbox"/> <input type="checkbox"/> Drug Dependency |

Do you have or have you had **any** other medical problems or surgeries that we have not already discussed? Describe: _____

F. Please answer the following questions.

1. What medications and/or herbal remedies are you currently taking? _____

Were any of these medications and/or herbal remedies taken in the last 24 hours? If so, which ones?

2. When was the last time you smoked cigarettes, cigars, a pipe or chewed tobacco? _____

3. How often do you consume caffeine (e.g., in coffee, tea, cola, chocolate)? _____

Thank you!