the royal victorian eye and ear hospital

Balance Disorders & Ataxia Service

Symptom Questionnaire

UR No: .....
Surname: .....
Given Name: .....
Date of Birth: .....
Gender: M or F or unspecified
Address: .....
.....
.....

Date: __ / __ / ____

Relationship Status: Single ☐ Married ☐ Partnered ☐

Occupation: _____

Please tick all boxes that apply to you

Description of your dizziness / imbalance:

- ☐ I am / the room is spinning
- ☐ I am / the room is moving or rocking
- ☐ I feel like I am going to fall
- ☐ I feel unsteady in my head
- ☐ I feel lightheaded / like I am going to faint
- ☐ I feel pressure in my head / headache
- ☐ I am / the room is tilting
- ☐ I lose my balance
- ☐ I veer / fall to one side
- ☐ I feel unsteady in my legs
- ☐ I black out / lose consciousness
- ☐ I feel unclear / foggy in my head

Other symptoms:

- ☐ Headache
- ☐ Weakness in my arms / legs
- ☐ Blurry vision
- ☐ Spots in my vision
- ☐ Bright lights bother me
- ☐ Loud noises bother me
- ☐ Noises in my ears - If so, please describe them: _____
- ☐ Difficulty hearing
- ☐ Tingling around my mouth
- ☐ Double vision
- ☐ Nausea or vomiting
- ☐ Difficulty speaking
- ☐ Fullness / pressure in my ears

I feel dizzy/I get my symptoms when:

- ☐ I am not moving
- ☐ I look up
- ☐ I roll in bed
- ☐ I exercise
- ☐ I use an elevator
- ☐ I am in a crowd
- ☐ I am walking
- ☐ I turn around
- ☐ I get up from bed
- ☐ I hear loud noises
- ☐ I use an escalator
- ☐ I am in a supermarket / shopping centre
- ☐ I move my head quickly
- ☐ I cough / blow my nose / strain
- ☐ I stand up from a sitting position
- ☐ I walk in the dark
- ☐ I travel in a boat / plane / car

Please answer the following:

Other triggers for symptoms, not mentioned on the previous page: _____

_____

When did the dizziness first occur? _____

What, if anything, makes the dizziness worse? _____

_____

What, if anything, makes the dizziness better? _____

_____

Is the dizziness: ☐ Constant ☐ Occurs in attacks

If the dizziness occurs in attacks:

How often do the attacks occur?_____

How long do the attacks last? _____

Are there any warning signs before an attack? _____

Are you completely free of dizziness between attacks? ☐ Yes ☐ No

If not, what symptoms do you have between attacks? _____

_____

Please list any scans, hearing or balance testing that you have had: _____

_____

_____

_____

FALLS HISTORY - Have you had any falls or near falls? ☐ Yes ☐ No

If so, please describe what happened: _____

_____

_____

_____

FAMILY HISTORY - One or more of my relatives suffer from:

☐ Dizziness / balance problems ☐ Hearing loss starting at less than 40 years of age

☐ Meniere's Disease ☐ Convulsions or seizures

☐ Migraines / headaches Other: _____

SOCIAL HISTORY –

Are you a sole carer for a child (under 18) or adult (over 18)? ☐ Yes ☐ No

Have your symptoms affected your emotional well-being? ☐ Yes ☐ No

Have you stopped going out or doing activities you enjoy because of your dizziness?

☐ Yes ☐ No

If yes for any of the above, please describe: _____

_____

_____

_____

MEDICAL CONDITIONS - Please list any medical conditions you have had in the past or have now:

_____

_____

_____

_____

Do you have any history of anxiety / depression / other mental health issues? Please list

_____

_____

Have you ever seen a psychiatrist or psychologist? ☐ Yes ☐ No

CURRENT MEDICATIONS

Please list all medications you take, including those prescribed by a doctor or purchased in a pharmacy, supermarket or health food store*:*

_____

_____

_____

Please list any medications that you are allergic to: _____

_____

_____