



PATIENT NAME: \_\_\_\_\_  
Date of Birth \_\_\_\_\_

DATE: \_\_\_\_\_

Equilibrium (balance) disorders may appear with a variety of symptoms. Some individuals may experience dizziness or vertigo (sense of themselves or the world spinning) while others may have imbalance or unsteadiness. Please spend a few minutes answering these questions regarding your history and symptoms. Please circle the answer(s) or write a response that best describes your situation.

1. Describe the symptoms you are experiencing:

Spinning    Lightheaded    "Swimmy headed"    Passing out    Drunk feeling  
Unsteadiness    Imbalance    Tendency to veer to the right----left----forward----backward  
Other: \_\_\_\_\_

2. When did the symptoms first appear? \_\_\_\_\_ When was your last episode? \_\_\_\_\_

3. How long do the symptoms last (per episode)?

Few seconds    Seconds to minutes    Minutes to several hours    Hours to days  
Continuous    Other: \_\_\_\_\_

4. How often do you experience the symptoms?

Only once    More than once: Several times a day -----week-----month-----year

5. When do the symptoms occur?

Without warning    Standing up    Head movements (right----left----both)    Loud sounds  
Sneezing    Straining    Rolling over in bed    Stress    High salt diet  
Other: \_\_\_\_\_

6. Do any of the following occur at the same time as the symptoms?

Hearing loss    Tinnitus (ringing or roaring)    Headaches    Facial numbness    Anxiety  
Change in vision    Pain (describe: \_\_\_\_\_)    Pressure in the head/ears  
Nausea/Vomiting    Other: \_\_\_\_\_

7. Have the symptoms changed since the first episode?    Yes                    No  
If Yes: Better ----- Worse                    Shorter duration ----- Longer duration  
More frequently ----- Less frequently        More intense ----- Less intense

8. I have the following medical conditions:  
Diabetes        Strokes        Hypertension        Coronary artery disease        Visual difficulty  
Seizures        Migraines        Anxiety/Panic attacks        Depression        Neurological disorders  
Head/neck injury        Motion sickness        Hearing Loss        Other: \_\_\_\_\_

9. Have you ever had any of the following?  
Intravenous antibiotics        Radiation Therapy        Ear surgery (describe: \_\_\_\_\_)  
Chemotherapy        Syphilis        Noise exposure

10. Does anyone in your immediate family have:  
Migraines        Meniere's disease        Neurological disorders        Anxiety/Panic attacks  
Depression        Hearing loss        Motion sickness

11. The level of my disability from the symptoms is best described as:  
 I am able to perform my daily activities, drive, and feel no ill effects from the symptoms.  
 I can continue to function with the symptoms but not optimally.  
 I need to stop when I experience the symptoms, but can return to my activities soon thereafter.  
 I am incapacitated for extended periods of time because of the symptoms.  
 I am unable to leave the house.

12. Is there anything else you would like us to know about your symptoms?

PLEASE COMPLETE THIS FORM AND BRING IT WITH YOU TO YOUR APPOINTMENT. YOU MAY ALSO RETURN IT TO US PRIOR TO YOUR APPOINTMENT. This will allow your appointment time to be used more efficiently.

Please contact Glenda Rast, Au.D., at (830) 627-3777 if you have any questions. Our fax number is (830) 627-3778. Dr. Rast may also be contacted via e-mail at [grast@entcenter-nb.com](mailto:grast@entcenter-nb.com).

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