

Balance Disorders Center
University ENT Specialists, Inc.
222 Piedmont Avenue, Suite 5200
Cincinnati, OH 45219-2276
(513) 475-8400 FAX (513) 475-8410

Name: _____ Birthdate: _____ Date: _____

Phone Numbers: Home _____ Work _____

Address: _____

Referring Physician: _____ Their Phone # _____

Gender: _____ Education: (total years completed) _____ Marital Status: _____

Current Place of Residence (check appropriate response)

- | | | | |
|--------------|-------|------------------------------|-------|
| a. house | _____ | d. assistive living facility | _____ |
| b. apartment | _____ | e. nursing home | _____ |
| c. condo | _____ | f. other (describe) | _____ |

Which University ENT Physician were you referred to: _____

Please describe your balance disorder (please include (if applicable) the date your disorder started, indicate whether it was sudden or gradual, how often it occurs, and how debilitating it is: _____

Do you know of any possible cause for your balance disorder? _____

Please circle the response number that would best describe your current overall balance disorder (0 to 5)

- 0 No disability, no symptoms
- 1 Slight disability, bothersome symptoms
- 2 Mild disability, performs usual duties, but symptoms interfere with social activities
- 3 Moderate disability, disrupts usual duties of everyday living
- 4 Recent severe disability, on medical leave or had to change job
- 5 Long term severe disability, unable to work for past year or longer

Description of Balance Disorders: (Check all that apply)

I feel:

- lightheaded
- unsteady
 - when standing
 - when walking
- as if I were spinning (vertigo)
- things around me move
- I tend to fall:
 - which directions _____

- I get nervous/panic when walking
- other (describe) _____
- _____
- _____

My symptoms are:

- severe
- moderate
- mild

- My symptoms are intermittent, they last:
 - seconds
 - minutes
 - hours
 - days
- My symptoms are constant

**Description of symptoms associated with my balance problem:
(Check all that apply)**

- nausea or vomiting
- loss of consciousness
- memory loss
- blurred or double vision
- weakness/numbness in arms, legs, face
- difficulty walking in the dark
- hot/cold sweats

- fainting
- headaches/migraines
- difficulty concentrating
- pain or stiffness in neck
- slurring of speech
- heart rate increases/decreases
- other (describe) _____
- _____
- _____

The following activities make my balance disorder worse: (Check all that apply)

- lay down from sitting
- sit up from laying
- stand up from sitting
- sudden movement
- turning head: right or left
- turning body: right or left
- bending down/leaning forward
- looking up or down
- physical exertion

- loud sounds/noises
- bright lights
- riding in a car
- riding in elevators or escalators
- walking down a store aisle
- stress/anxiety
- coughing/sneezing
- rolling over in bed: right or left
- other (describe) _____
- _____
- _____

My ear symptoms include: (Circle which ear it affects)

- | | | | |
|---------------------------------|------|-------|------|
| _____ hearing difficulty | Both | Right | Left |
| _____ noises in ear | Both | Right | Left |
| _____ ear pressure/fullness | Both | Right | Left |
| _____ ear drainage | Both | Right | Left |
| _____ ear pain | Both | Right | Left |
| _____ history of noise exposure | Both | Right | Left |

Medical History: (Check all that apply)

- | | |
|---|--------------------------------------|
| _____ Parkinson's Disease | _____ Depression |
| _____ Fatigue | _____ Loss of limb (arm, leg) |
| _____ Multiple Sclerosis | _____ Osteoporosis |
| _____ Migraines | _____ Headaches |
| _____ Ulcer | _____ Memory Loss |
| _____ High Blood Pressure | _____ Anemia |
| _____ Thyroid Disease | _____ Sinusitis |
| _____ Tumor or Cancer | _____ Asthma/Allergies |
| _____ Circulation Problems | _____ Head or neck injury |
| _____ Diabetes | _____ Visual problems/eye disorders |
| _____ Stroke | _____ Seizures/Convulsions |
| _____ Heart attack/disease | _____ Pulmonary/Respiratory problems |
| _____ Arthritis | _____ Hip or leg problems |
| _____ Glaucoma | _____ Cataracts |
| _____ Macular Degeneration | _____ Neck or back problems |
| _____ Tobacco use; | _____ Alcohol use; |
| how much _____ | how much _____ |
| _____ Other substance abuse (describe _____ | |

Did you have the flu, cold or respiratory infection prior to the onset of your balance problem? _____

Did you fly or deep water dive shortly before the onset of your balance disorder?

Do you have a family history of balance problems? If so, who in relation to you had it? _____

List the number and name of current medications you take and why:

Ever taken streptomycin, kanamycin, other “mycin” antibiotics, quinine, or antimalaria medications?

List the type of surgeries you have had and why they were performed: _____

List any previous balance tests, x-rays, MRI, CT scans, etc... you have already had, when you had these tests, and the name of the physician who requested these tests:

Fall Related History: (Circle Yes or No)

- | | | |
|---|-----|----|
| 1. Do you live alone? | YES | NO |
| 2. Do you need assistance to walk? | YES | NO |
| 3. Can you easily walk up stairs? | YES | NO |
| 4. Can you walk 10-20 meters without assistance? | YES | NO |
| 5. Do you use a walker, cane or roller walker? | YES | NO |
| 6. Do you hold onto a spouse or loved one while walking? | YES | NO |
| 7. Do you engage in regular physical exercise? | YES | NO |
| 8. Have you ever had a near fall experience? | YES | NO |
| 9. Have you ever fallen? | YES | NO |
| 10. Did you have an injury from the fall? | YES | NO |
| 11. Were you hospitalized due to a fall? | YES | NO |
| 12. Are you afraid of falling? | YES | NO |
| 13. Do you think your spouse is afraid that you might fall? | YES | NO |
| 14. Do you think your family members or friends are afraid that you might fall? | YES | NO |
| 15. Does your fear of falling prevent you from doing activities around the house? | YES | NO |
| 16. Does your fear of falling prevent you from doing activities outside of the house? | YES | NO |