ROCKY MOUNTAIN
HEARING AND BALANCE

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BALANCE HISTORY FORM

Name: _____ DOB: _____ Date: _____

1. Please indicate any symptom or sensation you are experiencing.

   □ Spinning □ Lightheadedness □ Unsteadiness □ Motion Sensation
   □ Nausea □ Other: _____

2. Symptoms came on:
   □ Gradually □ Suddenly

3. When did these symptoms begin?

4. How long do symptoms last?
   □ Seconds □ Seconds to minutes □ Minutes to hours □ Hours to days
   □ Continuous □ Other: _____

5. When do symptoms occur?
   □ Lying down □ Standing up □ Straining/sneezing/coughing
   □ Rolling over in bed □ Loud sounds □ Other_____
   □ Head movement

6. Episodes/attacks occur:
   □ Daily □ Weekly □ Monthly □ Randomly

7. Are you free from dizziness between attacks?
   □ Yes □ No

8. When was your last episode/attack?

9. Symptoms have:
   □ Improved since onset □ Worsened since onset □ Remained the same since onset

10. Please check all that seem to be **<u>related to your symptoms:</u>**
    □ Falling to the right side □ Severe headaches □ Visual disturbances/auras (spots
    □ Falling to the left side □ Recurrent headaches before eyes, flashing lights, etc.)
    □ Trouble walking in the dark □ Light sensitivity □ Fainting/loss of consciousness
    □ Numbness in feet/neuropathy □ Sound sensitivity □ Other_____
    □ Numbness in face □ Migraines

PLEASE TURN OVER AND COMPLETE THE REVERSE SIDE

11. Check all that apply to your **hearing:**

□ Difficulty hearing
How Long: _____
□ Previous Ear Surgery
When: _____
□ Change in **right** ear hearing when dizzy
□ Currently Wear Hearing Aids
How Long: _____
□ Tinnitus (Ringing/buzzing/hissing in ears)
□ Fullness/Aural pressure
□ Change in **left** ear hearing when dizzy

12. How many falls have you had **due to your symptoms** in the past 6 months?

13. Are you concerned about falling in the future?
□ Yes □ No

14. What **other tests** have been completed to look into your symptoms:
□ Hearing test □ CT scan of head □ MRI of head □ Blood work □ EKG

15. Please check all that apply to **your medical history:**

□ Stroke
□ High blood pressure
□ Low blood pressure
□ Heart problems
□ Neurological disorders
□ Migraines
□ Family history of migraines
□ Severe headaches
□ Depression
□ Anxiety
□ Neck problems
□ Back problems
□ Head injury
□ Carbon monoxide exposure
□ Other _____

16. Current **medications:**

Name of Medication	Reason for taking (e.g. blood pressure)	Recent change in prescription (Yes or No)	Have you taken this medication in the past 48 hours? (Yes or No)

_____ _____
Patient's Signature Date