NYHD | INSTITUTE FOR HEARING & BALANCE

Patient Name: _____

Date: _____

Past Medical History

Do you have, or have you had, any of the following?

Neurologic

☐ Migraine
☐ Stroke/TIA
If so, when? _____
☐ Parkinson's Disease
☐ Seizures/ Epilepsy
☐ Concussion/Head Injury
If so, when? _____
☐ Multiple Sclerosis
☐ Alzheimer's
☐ Other Neurologic _____

Cardiovascular

☐ Heart Attack
If so, when? _____
☐ Pacemaker
☐ Peripheral Arterial Disease
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Other Cardiovascular_____

Respiratory

☐ Breathing Difficulties
☐ Emphysema/COPD
☐ Asthma
☐ Other Respiratory _____

Other Health Issues:

_____
_____
_____
_____

Orthopedic

☐ Artificial Joints
If yes, which?_____
☐ Arthritis
☐ Back Problems
☐ Back Surgery
If so, when? _____
☐ Neck Problems
☐ Osteoporosis/Osteopenia
☐ Other Orthopedic_____

Vision

☐ Cataracts
If removed, when?_____
☐ Glaucoma
☐ Macular Degeneration
☐ Other Vision _____

Other

☐ Cancer
Type: _____
☐ Diabetes
☐ Neuropathy
☐ Depression
☐ Anxiety
☐ Thyroid
☐ Gastrointestinal Problems
☐ Rheumatoid Arthritis
☐ Tobacco Use
If yes, how much?_____
☐ Alcohol Use
If yes, how much?_____

Continue to next page

Patient Name: _____

Date: _____

Patient Questionnaire

Equilibrium disorders may appear with a variety of symptoms. Some individuals may experience dizziness or vertigo while others may have imbalance or unsteadiness. Please spend a few minutes answering the questions regarding your history and symptoms. Answer the questions to the best of your ability but please be assured that how you answer will not affect your evaluation.

How or when did your problem first occur? _____
How long did it last? _____

I. Do you experience any of the following sensations? Please read the entire list first. Then put an 'x' in either the first box for YES or the second box for NO to describe your feelings most accurately.

YES	NO	
☐	☐	Do you experience motion, air or sea sickness?
☐	☐	Did you have motion sickness as a child?
☐	☐	Do you have a family history of motion sickness? parent?____sibling?____child?____
☐	☐	Do you have migraine headaches?
☐	☐	Were you exposed to any solvents, chemicals, etc.?
☐	☐	Have you ever fallen? How many times? _____ Where? _____ Inside the home? _____ Outside the home? _____
☐	☐	Are you afraid of falling?

II. If you have dizziness, please check the box for either YES or NO, and fill in the blank spaces. If you do not experience dizziness, please go to the next section (III).

YES	NO	
☐	☐	My dizziness is constant? If you answered yes, please go to section III.
☐	☐	If in attacks, how often? _____
☐	☐	Are you completely free of dizziness between attacks?
☐	☐	Do you have any warning that the attack is about to start?
☐	☐	Is the dizziness provoked by head/body movement? If so, which direction?_____
☐	☐	Is the dizziness worse at any particular time of the day? If so, when? _____
☐	☐	Do you know of anything that will stop your dizziness or make it better? What? _____
☐	☐	…… make your dizziness worse? What? _____
☐	☐	…… precipitate an attack? What? _____
☐	☐	Do you know any possible cause of your dizziness? What? _____

Patient Name: _____

Date: _____

Page 2: Continuation (*Patient Questionnaire)*

III. Do you experience any of the following sensations? Please read the entire list first then please check the box for either YES or NO to describe your feelings most accurately.

YES	NO	
☐	☐	Light headedness?
☐	☐	Swimming sensation in the head?
☐	☐	Blacking out or loss of consciousness?
☐	☐	Objects spinning or turning around you?
☐	☐	Sensation that you are turning or spinning inside, with outside objects remaining stationary?
☐	☐	Tendency to fall……. to the right or left.
☐	☐	……. forward or backward
☐	☐	Loss of balance when walking….. veering to the right?
☐	☐	…… veering to the left?
☐	☐	Do you have trouble walking in the dark?
☐	☐	Do you have problems turning to one side or the other?
☐	☐	Nausea or vomiting?
☐	☐	Pressure in the head?

IV. Have you ever experienced any of the following symptoms? Please check the box for either YES or NO and circle if Constant or if In Episodes.

YES	NO			
☐	☐	Double vision?	Constant	In Episodes
☐	☐	Blurred vision or blindness?	Constant	In Episodes
☐	☐	Spots before your eyes?	Constant	In Episodes
☐	☐	Numbness of face, arms or legs?	Constant	In Episodes
☐	☐	Weakness in arms or legs?	Constant	In Episodes
☐	☐	Confusion or loss of consciousness?	Constant	In Episodes
☐	☐	Difficulty in swallowing?	Constant	In Episodes
☐	☐	Tingling around the mouth?	Constant	In Episodes
☐	☐	Difficulty speaking?	Constant	In Episodes

V. Do you have any of the following? Please check the box for either YES or NO and circle the ear involved.

YES	NO				
☐	☐	Difficulty in hearing?	Both Ears	Right Ear	Left Ear
		When did this start? _____	Is it getting worse? _____		
		Does the hearing change with your symptoms? If so, how? _____			
☐	☐	Noise in your ears?	Both Ears	Right Ear	Left Ear
		Describe the noise? _____			
		Does the noise change with your symptoms? If so, how? _____			
☐	☐	Does anything stop the noise or make it better? _____			
☐	☐	Fullness or stuffiness in your ears?	Both Ears	Right Ear	Left Ear
		Does this change when you are dizzy? _____			
☐	☐	Pain in your ears?	Both Ears	Right Ear	Left Ear
☐	☐	Discharge from your ears?	Both Ears	Right Ear	Left Ear

Patient Name: _____

Date: _____

Initial Visit / Follow-up / Discharge

The Dizziness Handicap Inventory (DHI)

PLEASE MARK AN "X" IN THE APPROPRIATE BOX REGARDING YOUR DIZZINESS/IMBALANCE SYMPTOMS

		YES	SOMETIMES	NO
P1	Does looking up increase your problem?			
E2	Because of your problem, do you feel frustrated?			
F3	Because of your problem, do you restrict your travel for business or recreation?			
P4	Does walking down the aisle of a supermarket increase your problems?			
F5	Because of your problem, do you have difficulty getting into or out of bed?			
F6	Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to the movies, dancing, or going to parties?			
F7	Because of your problem, do you have difficulty reading?			
P8	Does performing more ambitious activities such as sports, dancing, household chores (sweeping or putting dishes away) increase your problems?			
E9	Because of your problem, are you afraid to leave your home without having without having someone accompany you?			
E10	Because of your problem have you been embarrassed in front of others?			
P11	Do quick movements of your head increase your problem?			
F12	Because of your problem, do you avoid heights?			
P13	Does turning over in bed increase your problem?			
F14	Because of your problem, is it difficult for you to do strenuous homework or yard work?			
E15	Because of your problem, are you afraid people may think you are intoxicated?			
F16	Because of your problem, is it difficult for you to go for a walk by yourself?			
P17	Does walking down a sidewalk increase your problem?			
E18	Because of your problem, is it difficult for you to concentrate?			
F19	Because of your problem, is it difficult for you to walk around your house in the dark?			
E20	Because of your problem, are you afraid to stay home alone?			
E21	Because of your problem, do you feel handicapped?			
E22	Has the problem placed stress on your relationships with members of your family or friends?			
E23	Because of your problem, are you depressed?			
F24	Does your problem interfere with your job or household responsibilities?			
P25	Does bending over increase your problem?			

Used with permission from GP Jacobson. Jacobson GP, Newman CW: The development of the Dizziness Handicap Inventory. Arch Otolaryngol. Head Neck Surg 1990;116: 424-427

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For Office Use Only
Score P: _____ E: _____ F: _____

16-34 Points (mild)
36-52 Points (moderate)
54+ Points (severe)