Providence Health Care

Place Patient Label Here

DIZZINESS/BALANCE QUESTIONNAIRE
COCHLEAR IMPLANT PROGRAM
PATIENT QUESTIONNAIRE

* 8 1 9 9 *

Medical Questionnaire

Date: (mmm/dd/yyyy) _____

1. Have you ever experienced dizziness / vertigo / imbalance?

   ☐ No (NOTE: This form is to be returned even if you have marked "NO")

   ☐ Yes If "Yes", please complete questions 2 to 6.

2. a. When did you first experience dizziness?: (e.g. "March 2016" or "10 years ago" if you cannot recall specifics)

   _____

   b. Please describe any severe dizziness episodes you have had. Be sure to include the following details:

   - What the dizziness felt like (e.g. spinning, floating, rocking, tilting, drunk, unsteady, etc.)
   - Whether you were nauseated and/or vomiting
   - Whether your hearing and/or tinnitus changes at the same time
   - On average, how long dizziness episode(s) last (i.e. seconds / minutes/ hours/ days?)

   _____

   _____

   _____

   _____

   _____

   _____

3. How many episodes have you had _____(approximately) and/or how often do they occur? _____

4. When was your last episode? (e.g. "March 2016" or "10 years ago" if you cannot recall specifics): _____

5. Do you still have dizziness? ☐ No ☐ Yes

   If you answered yes, please complete the questions below:

   a. Do you have dizziness when you change positions? (e.g. rolling over in bed or lying down) ☐ No ☐ Yes
   b. Do loud sounds and/or pressure changes make you dizzy? ☐ No ☐ Yes
   c. Do you have dizziness when you strain physically? ☐ No ☐ Yes
   d. I have the following medical problems (check all that apply):

   ☐ motion sickness ☐ migraines ☐ diabetes ☐ I have had a stroke

   ☐ heart disease ☐ visual problems ☐ anxiety/depression ☐ high blood pressure ☐ low blood pressure

   ☐ seizures ☐ neck problems ☐ other _____

6. List medications you are taking regularly or as needed below:

   _____

   _____