Better Hearing
& Balance Connection

**Balance Confidence Scale**

**How confident are you that you can do these activities without losing your balance? Rate your confidence level for each activity from 0% to 100%. You don't have to total your scores.**

**0% = No Confidence** **100% = Completely Confident**

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1. **Walk around the house** _____%
2. **Walk up and down stairs** _____%
3. **Pick up a shoe from the floor** _____%
4. **Reach for something at eye level** _____%
5. **Reach for something while standing on tip-toe** _____%
6. **Stand on a chair to reach for something** _____%
7. **Sweep the floor** _____%
8. **Walk outside to a nearby car** _____%
9. **Get out of a car** _____%
10. **Walk across a parking lot** _____%
11. **Walk up and down a ramp** _____%
12. **Walk in a crowded mall** _____%
13. **Walk in a crowd where you might be bumped** _____%
14. **Ride an escalator while holding a rail** _____%
15. **Ride an escalator while not holding a rail** _____%
16. **Walk on icy sidewalks** _____%

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**Total** _____%

**Average (total/16)** _____%

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# Dizziness Questionnaire

**I. When you are "dizzy" do you experience any of the following sensations? Please read the list first. Mark either the "yes" or "no" line for each item and mark the one that most accurately describes your feelings about each listed sensation.**

| YES | NO | |
|---|---|---|
| ____ | ____ | Lightheadedness |
| ____ | ____ | Swimming sensation in the head |
| ____ | ____ | Blacking out |
| ____ | ____ | Loss of consciousness |
| ____ | ____ | Objects spinning or turning around you |
| ____ | ____ | Turning or spinning inside, with outside objects remaining stationary |
| ____ | ____ | Headache |
| ____ | ____ | Nausea or vomiting |
| ____ | ____ | Pressure in the head |

Sensation of falling

| YES | NO | |
|---|---|---|
| ____ | ____ | To the right |
| ____ | ____ | To the left |
| ____ | ____ | Forward |
| ____ | ____ | Backward |

Sensation of losing balance when walking

| YES | NO | |
|---|---|---|
| ____ | ____ | Veering to the right |
| ____ | ____ | Veering to the left |

**II. Mark either the "yes" or the "no" line for each item and write in answers on the blank lines when provided.**

My dizziness is:

| YES | NO | |
|---|---|---|
| ____ | ____ | Constant |
| ____ | ____ | Comes in attacks |

Where were you when your dizziness first occurred?_____

If it occurs in attacks, how often?_____

How long do the attacks last?_____

| YES | NO | |
|---|---|---|
| ____ | ____ | Do you have warning that the attack is about to begin? |
| ____ | ____ | Are you completely free of dizziness between attacks? |
| ____ | ____ | Does dizziness occur only in certain positions? |
| ____ | ____ | Do you have trouble with walking in the dark? |

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## Dizziness Questionnaire

YES NO

____ ____ When youa re dizzy, must you support yourself while standing?
____ ____ Do you know of any possible cause of your dizziness?
Do you know of anything that will:
YES NO
____ ____ Stop your dizziness or make it better
____ ____ Make your dizziness worse
____ ____ Happen before an attack of dizziness
____ ____ Were you exposed to any irritations, fumes, paints, etc., at the onset of dizziness?
____ ____ Do you have any allergies?
____ ____ Did you ever injure your head?
____ ____ Were you unconscious?
____ ____ Do you take any medications regularly (i.e. tranquilizers, oral contraceptives, barbiturates, antibiotics) What?_____
____ ____ Do you use tobacco in any form? How much?_____
____ ____ Do you use alcohol?
____ ____ Have you ever had ear surgery?

III. Do you have any of the following symptoms? Mark either the "yes" or the "no" line for each item. Circle which ear is affected or write in answers on the blank lines provided.

YES NO

____ ____ Difficulty in hearing? BOTH EARS RIGHT EAR LEFT EAR
When did this begin?_____
____ ____ Is it getting worse?
____ ____ Noise in your ears? BOTH EARS RIGHT EAR LEFT EAR
Describe the noise:_____
____ ____ Does the noise change with dizziness? If so, how so?

_____

____ ____ 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

IV. Have you ever experienced any of the following symptoms? Mark either the "yes" or the "no" line for each item. Circle "CONSTANT" or "IN EPISODES" to describe how frequently you experience the problem.

YES NO

____ ____ Double Vision CONSTANT IN EPISODES
____ ____ Numbness of face or extremities CONSTANT IN EPISODES
____ ____ Blurred vision or blindness CONSTANT IN EPISODES
____ ____ Weakness in arms or legs CONSTANT IN EPISODES
____ ____ Clumsiness in arms or legs CONSTANT IN EPISODES
____ ____ Confusion or loss of consciousness CONSTANT IN EPISODES
____ ____ Difficulty with speech CONSTANT IN EPISODES

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## Dizziness Questionnaire

| YES | NO | | | |
|---|---|---|---|---|
| ____ | ____ | Difficulty with swallowing | CONSTANT | IN EPISODES |
| ____ | ____ | Tingling around the mouth | CONSTANT | IN EPISODES |
| ____ | ____ | Spots before the eyes | CONSTANT | IN EPISODES |

IV. Mark either the "yes" or the "no" line for each item.

| YES | NO | |
|---|---|---|
| ____ | ____ | Do you get dizzy after exertion or overwork? |
| ____ | ____ | Did you get new glasses recently? |
| ____ | ____ | Do you tend to get upset easily? |
| ____ | ____ | Do you get dizzy when you have not eaten for a long time? |
| ____ | ____ | Is your dizziness connected with your menstrual period? |
| ____ | ____ | Have you ever had a neck injury? |

**Please bring the completed form to your scheduled VNG evaluation or fax your information to 479-657-6609.**