

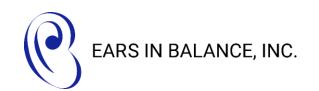
Please follow instructions carefully before coming for you Balance tests.

Failure to do so will result in wrong diagnosis. Ensure that you have an accompanying driver to take you back home after the tests.

BALANCE QUESTIONNAIRE

Patients: In order to fully evaluate your complaints, please complete all questions and bring this survey with you when you return for you balance function testing.

1.	. Describe symptoms / complaints in detail:							
2.	. When did symptoms begin:							
3.	How long do	symptoms Minutes						
4.	How often d Constant	o symptoms Daily	s occur: Weekly	Monthly	Yearly			
5.	Symptoms of	occur when:						
	Walking	Standing	Sitting	Laying	Anytime			



BALANCE QUESTIONNAIRE

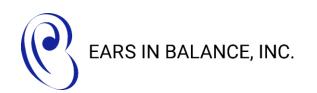
	NO	YES	Comments
Imbalance / Unsteadiness			
History of falling			
Spinning / Tumbling			
Rocking / Swaying			
Lightheadedness			
Fainting / Black Out			
Nausea / Vomiting			
Double Vision			
Jumping Vision (while walking / Riding)			

Are symptoms worsened by:

The symptoms tronsened by:	NO	YES	Comments
	NO	TES	Comments
Lying down or rolling over			
Sitting or standing up			
Walking in darkness			
Rocking / Swaying			
Walking on uneven surfaces			
Hot baths / showers			
Menstrual Cycle			
Exercise			
Reading / Computer work			
Loud Noises			
Coughing, Sneezing, Straining			

Ears / Eyes:

	NO	RIGHT	LEFT	Comments
Fluctuating Hearing				
Tinnitus (ringing, buzzing, etc.)				
Frequent Ear Infections				
Perforated / Torn Eardrum				
Ear Surgery				
Ear Injuries				
Eye Injury				
Eye Surgery				
Use of Eye Patch				



Headache History

Headaches	:	No	Yes			
How often do they occur	:	Daily	Weekly	Monthly		
How long do they last?	:	Minutes	Hours	Days		
Headache medications List	:					
Migraine	:	No	Yes			
Since how long?	:					
With nausea / vomiting	:	No	Yes			
Caused by certain food / dri	ink:	No	Yes			
Family history of migraine	:	No	Yes			
Related to Menstrual cycle	:	No	Yes			
Habits:						
Past Medical History: Please Describe and list dates.						
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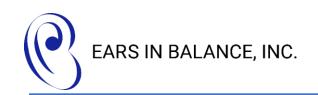
Motor Vehicle Accident:

Head Injury:

Chronic Illness (e.g., diabetes, hypertension) requiring medication:

Intravenous antibiotics, chemotherapy, radiation therapy:

Medications: Please List



Name:	
Date:	

The purpose of the scale is to identify the problems your tinnitus may be causing you.

Circle "YES," "Sometimes," or "NO" for each question. Do not skip a question.

1. Because of your tinnitus is it difficult to	Yes / Sometimes / No
concentrate?	,
2. Does the loudness of your tinnitus make it	Yes / Sometimes / No
difficult for you to hear people?	
3. Does you tinnitus make you angry?	Yes / Sometimes / No
4. Does your tinnitus make you feel confused?	Yes / Sometimes / No
5. Because of your tinnitus do you feel desperate?	Yes / Sometimes / No
6. Do you complain a great deal about your tinnitus?	Yes / Sometimes / No
	Vac / Camatimas / Na
7. Because of your tinnitus do you have trouble	Yes / Sometimes / No
falling to sleep at night?	
8. Do you feel that you cannot escape your tinnitus?	Yes / Sometimes / No
9. Does your tinnitus interfere with your ability to	Vac / Camatimas / Na
enjoy social activities (such as going out to	Yes / Sometimes / No
dinner, to the movies)?	
10. Because of your tinnitus do you feel	V /6 1: /N
frustrated?	Yes / Sometimes / No
11. Because of your tinnitus do you feel that you	Yes / Sometimes / No
have a terrible disease?	,
12. Does your tinnitus make it difficult for you to	Yes / Sometimes / No
enjoy life?	, ,
13.Does your tinnitus with your interfere with	Yes / Sometimes / No
your job or household duties?	, ,
14. Because of your tinnitus do you find that you	Yes / Sometimes / No
are often irritable?	. 35 / 555355 / 1.16
15. Because of your tinnitus is it difficult for you	
to read?	Yes / Sometimes / No
15. Does your tinnitus make you upset?	Yes / Sometimes / No
20. 2000 your difficult fluide you apoet.	100 / 001110011100 / 110
17. Do you feel that your tinnitus problem has	Yes / Sometimes / No
place stress on your relationship with members	res / sometimes / No
place 3d c33 off your relationship with members	

of your family and friends?	
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Tinnitus Handicap Inventory

18. Do you find it difficult to focus your attention away from your tinnitus and on other things?	Yes / Sometimes / No
19. Do you feel that you have no control over your tinnitus?	Yes / Sometimes / No
20. Because of your tinnitus do you often feel tired?	Yes / Sometimes / No
21. Because your tinnitus do you feel depressed?	Yes / Sometimes / No
22. Does your tinnitus make you feel anxious?	Yes / Sometimes / No
23. Do you feel that you can no longer cope with your tinnitus?	Yes / Sometimes / No
24. Does your tinnitus get worse when you are under stress?	Yes / Sometimes / No
25. Does your tinnitus make you feel insecure?	Yes / Sometimes / No