EARS IN BALANCE, INC.

EARS IN BALANCE, INC
18451. West 12 Mile Road
Suite 201
Lathrup Village, MI

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 last (circle answers):

   Seconds Minutes Hours Days

4. How often do symptoms occur:

   Constant Daily Weekly Monthly Yearly

5. Symptoms occur when:

   Walking Standing Sitting Laying Anytime

EARS IN BALANCE, INC.

EARS IN BALANCE, INC
18451. West 12 Mile Road
Suite 201
Lathrup Village, MI

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:

	NO	YES	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				

EARS IN BALANCE, INC.

EARS IN BALANCE, INC
18451. West 12 Mile Road
Suite 201
Lathrup Village, MI

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 / drink: No Yes

Family history of migraine : No Yes

Related to Menstrual cycle : No Yes

Habits: ____
Alcohol: ____
Caffeine: ____
Tobacco: ____
Recreation Drug: ____

Past Medical History: Please Describe and list dates.
____
____
Motor Vehicle Accident:
Head Injury:
Chronic Illness (e.g., diabetes, hypertension) requiring medication:
Intravenous antibiotics, chemotherapy, radiation therapy:
Medications: Please List

EARS IN BALANCE, INC.

EARS IN BALANCE, INC
18451. West 12 Mile Road
Suite 201
Lathrup Village, MI

Tinnitus Handicap Inventory

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 concentrate?	Yes / Sometimes / No
2. Does the loudness of your tinnitus make it difficult for you to hear people?	Yes / Sometimes / No
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
7. Because of your tinnitus do you have trouble falling to sleep at night?	Yes / Sometimes / No
8. Do you feel that you cannot escape your tinnitus?	Yes / Sometimes / No
9. Does your tinnitus interfere with your ability to enjoy social activities (such as going out to dinner, to the movies)?	Yes / Sometimes / No
10. Because of your tinnitus do you feel frustrated?	Yes / Sometimes / No
11. Because of your tinnitus do you feel that you have a terrible disease?	Yes / Sometimes / No
12. Does your tinnitus make it difficult for you to enjoy life?	Yes / Sometimes / No
13.Does your tinnitus with your interfere with your job or household duties?	Yes / Sometimes / No
14. Because of your tinnitus do you find that you are often irritable?	Yes / Sometimes / No
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
17. Do you feel that your tinnitus problem has place stress on your relationship with members	Yes / Sometimes / No

of your family and friends?	

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