University of Nebraska Lincoln

DEPARTMENT OF SPECIAL EDUCATION AND COMMUNICATION DISORDERS
Dizziness and Balance Disorder Lab
(402) 472-8790
dizzinesslab@unlnotes.unl.edu

Dear Patient:

Enclosed is a questionnaire used to assist in the scheduling of persons who come to the UNL Dizziness and Balance Disorder Laboratory. We request that you answer the questions to the best of your ability and return the form to our office in the enclosed envelope. If you have any comments that might help us, please write a note in the margin. The purpose of the questionnaire is to make your visit to our clinic more efficient. The information that you provide will assist us in scheduling your appointment, and avoiding duplication of previously performed dizziness, balance, or risk of falling testing. In addition to completing the attached questionnaire, we ask that you review these instructions regarding dizziness, balance, and risk of falling testing in our facility.

- All testing will take place at UNL Dizziness and Balance Disorder Laboratory.
- Our facility recommends a hearing test within six months prior to all dizziness, balance or risk of falling testing. Please fax these results to (402)-472-3814. If you do not have current hearing test results:
    - Obtain a referral from your physician for a hearing evaluation.
    - Schedule an appointment for a hearing test with an audiologist from the enclosed list OR the University of Nebraska Barkley Center in Lincoln (402)-472-2071.
- If you have had any previous dizziness, balance, or risk of falling testing, please bring these results with you to your appointment, or fax the results to (402)-472-3814.
- We suggest that you bring someone with you who can drive you home after the testing has been completed, especially if you are already unsteady or feeling dizzy.
- Certain medications may interfere with results of dizziness, balance, and risk of falling tests. We ask that you take only essential medications during the 2 days before your appointment. Examples of essential medications include: heart medicines, blood pressure medicines, diabetes medicines, seizure medicines, and psychiatric medicines. We ask that you avoid the following for 48 hours before your test: alcoholic beverages, sleeping pills, tranquilizers, narcotics, antihistamines, medications that make you dizzy (examples are Antivert and Robinul) and over the counter cold or allergy medications. The idea is that we don't want you to take any medications that affect your inner ear of balance, or, the brain pathways that connect to your inner ear of balance. It makes sense that the more "pure" are the conditions of the test, the more we can say about the test results.

Thank you in advance for returning this promptly. In order to speed up the process of scheduling your appointment, you may fax back your questionnaire to (402)-472-3814; please be sure to include a cover sheet to the attention of Julie Honaker. If you have any questions feel free to contact our office at (402) 472-2071.

Sincerely

Julie A. Honaker, Ph.D.
Director, Dizziness and Balance Disorder Laboratory

Case History Form

Date_____

Name_____
Last First M

Birth Date ___/___/___ Age_____ Gender: Female ___ Male ___

Description of Balance Problem

Please describe your balance problem and the date your disorder started, indicate whether it was sudden or gradual, how often it occurs, and how debilitating it is:

_____
_____
_____
_____
_____

Do you know of any possible cause for your balance problem?

_____
_____
_____
_____
_____

Do you have a family history of balance problems? Yes ____ No____
If yes, who in relation to you had it?_____

List the number and name of current medications you take and why:

_____
_____
_____
_____
_____

Ever taken streptomycin, kanamycin, other “mycin” antibiotics, quinine, or antimalaria medications? Yes ____ No _____
If yes, please describe the circumstances_____
_____

List any previous balance tests, x-rays, MRI, CT scans, etc… you have already had, when you had these tests, and the name of the physician who requested these tests:

_____
_____
_____
_____

Did you have the flu, cold or respiratory infection prior to the onset of your balance problem? Yes____ No ____
If yes, please describe the circumstances_____
_____

Did you fly or deep water dive shortly before the onset of your balance disorder?
Yes _____ No____
If yes, please describe the circumstances_____
_____

List the type of surgeries you have had and why they were performed: _____
_____
_____
_____

Description of Balance Problem: (Check all that apply)

I feel:
_____Lightheaded
_____Unsteady
_____ when standing
_____ when walking
_____ as if I were spinning (vertigo)
_____ as if things around me move
_____ I tend to fall:
which direction(s)_____
_____ I get nervous/panic when walking
_____ other (describe)_____
_____
_____
_____

My symptoms are:
_____ severe
_____ moderate
_____ mild
_____My symptoms intermittent, they last:
_____ seconds
_____ minutes
_____ hours
_____ days
_____My symptoms are constant

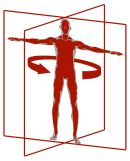
Description of symptoms associated with my balance problem:
(Check all that apply)

_____ nausea or vomiting
_____ loss of consciousness
_____ memory loss
_____ blurred or double vision
_____ weakness/numbness in arms, legs, face
_____ difficulty walking in the dark
_____ hot/cold sweats
_____ fainting
_____ headaches/migraines
_____ difficulty concentrating
_____ pain or stiffness in neck
_____ slurring of speech
_____ heart rate increases/decreases
_____ other (describe below)

_____
_____

The following activities make my balance disorder worse: (Check all that apply)

_____ lay down from sitting
_____ sit up from laying
_____ stand up from sitting
_____ sudden movement
_____ turning head: right or left
_____ turning body: right or left
_____ bending down/leaning forward
_____ looking up or down
_____ physical exertion
_____ loud sounds/noises
_____ bright lights
_____ riding in a car
_____ riding in elevators or escalators
_____ walking down a store aisle
_____ stress/anxiety
_____ coughing/sneezing
_____ rolling over in bed: right or left
_____ other (describe below)



_____

_____

Please circle the response number that would best describe your current overall balance disorder (0 to 5)

0 No disability, no symptoms
1 Slight disability, bothersome symptoms
2 Mild disability, performs usual duties, but symptoms interfere with social activities
3 Moderate disability, disrupts usual duties of everyday living
4 Recent severe disability, on medical leave or had to change job
5 Long term severe disability, unable to work for past year or longer

My ear symptoms include: (Circle which ear it affects)

_____ hearing difficulty	Both	Right	Left
_____ noises in ear	Both	Right	Left
_____ ear pressure/fullness	Both	Right	Left
_____ ear drainage	Both	Right	Left
_____ ear pain	Both	Right	Left
_____ history of noise exposure	Both	Right	Left

Medical History: (Check all that apply)

_____ Parkinson's Disease
_____ Fatigue
_____ Multiple Sclerosis
_____ Migraines
_____ Ulcer
_____ High Blood Pressure
_____ Thyroid Disease
_____ Tumor or Cancer
_____ Circulation Problems
_____ Diabetes
_____ Stroke
_____ Heart attack/disease
_____ Arthritis
_____ Glaucoma
_____ Macular Degeneration
_____ Tobacco use;
how much _____

_____ Depression
_____ Loss of limb (arm, leg)
_____ Osteoporosis
_____ Headaches
_____ Memory Loss
_____ Anemia
_____ Sinusitis
_____ Asthma/Allergies
_____ Head or neck injury
_____ Visual problems/eye disorders
_____ Seizures/Convulsions
_____ Pulmonary/Respiratory problems
_____ Hip or leg problems
_____ Cataracts
_____ Neck or back problems
_____ Alcohol use;
how much _____

_____ Other (describe below)

_____
_____
_____
_____
_____

Fall Related History: (Circle Yes or No)

1. Do you need assistance to walk?	YES	NO
2. Can you easily walk up stairs?	YES	NO
3. Can you walk 10-20 meters without assistance?	YES	NO
4. Do you use a walker, cane or roller walker?	YES	NO
5. Do you hold onto a spouse or loved one while walking?	YES	NO
6. Do you engage in regular physical exercise?	YES	NO
7. Have you ever had a near fall experience?	YES	NO
8. Have you ever fallen?	YES	NO
9. Did you have an injury from the fall?	YES	NO
10. Were you hospitalized due to a fall?	YES	NO
11. Are you afraid of falling?	YES	NO
12. Do you think your spouse is afraid that you might fall?	YES	NO
13. Do you think your family members or friends are afraid that you might fall?	YES	NO
14. Does your fear of falling prevent you from doing activities around the house?	YES	NO
15. Does your fear of falling prevent you from doing activities outside of the house?	YES	NO

The Activities-specific Balance Confidence (ABC) Scale

For <u>each</u> of the following 16 activities, please indicate your level of self-confidence by choosing a corresponding number from the following rating scale:

0% 10 20 30 40 50 60 70 80 90 100%

<u>no confidence</u> **<u>completely confident</u>**

"How confident are you that you will <u>not</u> lose your balance or become unsteady when you…

1. …walk around the house? ____%
2. …walk up or down stairs? ____%
3. …bend over and pick up a slipper from the front of a closet floor ____%
4. …reach for a small can off a shelf at eye level? ____%
5. …stand on your tiptoes and reach for something above your head? ____%
6. …stand on a chair and reach for something? ____%
7. …sweep the floor? ____%
8. …walk outside the house to a car parked in the driveway? ____%
9. …get into or out of a car? ____%
10. …walk across a parking lot to the mall? ____%
11. …walk up or down a ramp? ____%
12. …walk in a crowded mall where people rapidly walk past you? ____%
13. …are bumped into by people as you walk through the mall?____%
14. … step onto or off an escalator while you are holding onto a railing? ____%
15. … step onto or off an escalator while holding onto parcels such that you cannot hold onto the railing? ____%
16. …walk outside on icy sidewalks? ____%