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

Name_______________________________________________________

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:  My symptoms are:
      Lightheaded  severe
      Unsteady  moderate
      Unsteady when standing  mild
      Unsteady when walking  intermittent, they last:
      as if I were spinning (vertigo)  seconds
      as if things around me move  minutes
      I tend to fall:  hours
      which direction(s)  days
      I get nervous/panic when walking  My symptoms are constant
      other (describe)
      other (describe)
_____________________________________________________________________________________
_____________________________________________________________________________________

Description of symptoms associated with my balance problem:
(Check all that apply)
      nausea or vomiting  fainting
      loss of consciousness  headaches/migraines
      memory loss  difficulty concentrating
      blurred or double vision  pain or stiffness in neck
      weakness/numbness in arms, legs, face  slurring of speech
      difficulty walking in the dark  heart rate
increases/decreases
      hot/cold sweats  other (describe below)
_____________________________________________________________________________________

The following activities make my balance disorder worse: (Check all that apply)
      lay down from sitting  loud sounds/noises
      sit up from laying  bright lights
      stand up from sitting  riding in a car
      sudden movement  riding in elevators or escalators
      turning head:  right or left  walking down a store aisle
      turning body:  right or left  stress/anxiety
      bending down/leaning forward  coughing/sneezing
      looking up or down  rolling over in bed:  right or left
      physical exertion  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
- ______ Depression
- ______ Fatigue
- ______ Loss of limb (arm, leg)
- ______ Multiple Sclerosis
- ______ Osteoporosis
- ______ Migraines
- ______ Headaches
- ______ Ulcer
- ______ Memory Loss
- ______ High Blood Pressure
- ______ Anemia
- ______ Thyroid Disease
- ______ Sinusitis
- ______ Tumor or Cancer
- ______ Asthma/Allergies
- ______ Circulation Problems
- ______ Head or neck injury
- ______ Diabetes
- ______ Visual problems/eye disorders
- ______ Stroke
- ______ Seizures/Convulsions
- ______ Heart attack/disease
- ______ Pulmonary/Respiratory problems
- ______ Arthritis
- ______ Hip or leg problems
- ______ Tumor or Cancer
- ______ Cataracts
- ______ Macular Degeneration
- ______ Neck or back problems
- ______ Tobacco use; 
  - how much ______
- ______ 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 each of the following 16 activities, please indicate your level of self-confidence by choosing a corresponding number from the following rating scale:

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<th>0%</th>
<th>10</th>
<th>20</th>
<th>30</th>
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<td>no confidence</td>
<td>completely confident</td>
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“How confident are you that you will not 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? ____%