DIZZINESS AND BALANCE TEST
(TO BE COMPLETED BY PATIENT)

Woodbine DIZZINESS & BALANCE Clinic

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First Name, Last Name:		Appointment Date:	
OHIP:		Appointment Time:	

I. PATIENT'S QUESTIONAIRE

1. Describe what you are experiencing.
☐ Spinning ☐ Lightheaded ☐ Passing out ☐ Drunk feeling
☐ Other:_____

2. How long your dizziness last (if it comes in spells)?
☐ Few seconds ☐ Seconds to minutes ☐ Minutes to several hours
☐ Hours to days ☐ Continuous ☐ others:_____

3. **How often do you get dizzy?**
☐ Only once ☐ More than once ☐ Frequency:_____

4. **When do your attacks occur?**
☐ Standing up ☐ Head movement ☐ Loud sounds
☐ Sneezing Straining ☐ Rolling over in bed ☐ Stress
☐ Diet ☐ Other:_____

5. **Do any of the following occur with your typical attacks?**
☐ Hearing loss ☐ Tinnitus ☐ Headaches
☐ Facial numbness ☐ Anxiety ☐ Change in vision ☐ Pain
☐ Other:_____

6. **Do you have any of the medical conditions?**
☐ Diabetes ☐ Strokes ☐ Hypertension
☐ Visual difficulty ☐ Seizures ☐ Coronary artery disease
☐ Migraines ☐ Psychiatric disease: _____

7. What medications are you currently taking:_____
_____

8. Do you have had any of the following?
☐ Intravenous antibiotics ☐ Radiation Therapy ☐ Ear Surgery
☐ Chemotherapy ☐ Syphylis

9. **Has the dizziness changed since the first episode?** ☐ Yes ☐ No
If yes: ☐ Better ☐ Worse ☐ Shorter ☐ Longer

II. PATIENT CONSENT STATEMENT

I have read and have followed the instructions on the reverse of this page and fully understand the possible side effect.
I understand that I should not sign if all of my questions have not been answered to my satisfaction from my referring physician and the audiology clinicians.

I understand that I must sign this consent form to proceed the hearing and vestibular function test. I also understand the consent form and a copy of the test reports will be stored in my family doctor, referring physician, otolaryngologist, otolaryngologist's operating hospital, hearing clinic and vestibular function test clinic.

Name: _____

Date: _____

Signature: _____

Please see reverse side for the instructions for the test(s).

This questionnaire and consent form can be downloaded on www.balancetest.ca
Once you have completed it, please email it to info@balancetest.ca or fax it to 416 628 4006.