VNG Questionnaire

Name:______________________ Birthdate:__/__/___ Age:____

Dizziness

(Please answer questions pertaining to symptoms as of today)

How often do you have dizziness: ___ One Time ___ Daily ___ Weekly ___ Monthly

Would you describe it as lightheadedness or spinning: ________________________________

Does it last: ___ Seconds ___ Minutes ___ Hours ___ Days

When did it *FIRST* occur: ____

Symptoms associated with the dizziness: ___ Nausea
___ Vomiting
___ Hearing Loss - **Right or Left Ear: ______**
___ Tinnitus *(ringing)* - **Right or Left Ear: ______**
___ Full Feeling In Ear - **Right or Left Ear:** ______
___ Other: __________________________________

Symptoms are provoked with: ___ Head Motion
___ Vision/Sitting Still/Eyes Only – No Movement Needed
___ Changing Body Positions
___ Other: ____

Have you fallen recently: Yes / No **If yes, when:** ____________________________________

How many times have you fallen in the past year: ____________________________________

Do you have difficulty walking and getting around: Yes / No

Do you routinely use an assistive device to get around *(cane, wheelchair, walker etc.)*: Yes/ No

Have you ever been injured, broken bones, or lost consciousness as a result of a fall: Yes / No

Do you live alone: Yes / No

If yes, do you have family, friends or neighbors that check on you regularly: **Yes / No**

Do you have a phone or cell phone located within easy reach of the chair you usually sit in to view television: Yes / No

Do you routinely use a First Alert or similar system for emergencies: Yes / No

PLEASE TURN OVER FOR MORE QUESTIONS

Disequilibrium

Imbalance occurs: ___ Suddenly ___ Daily ___ Seldom ___ Never

How long: ___ Seconds ___ Minutes ___ Hours ___ Days

Symptoms associated with imbalance: ___ Unsteadiness

___ Shuffling

___ Veering: (___ **Right** ___ **Left)**

___ Falling: (**___ Forward ___Backward ___ Right ___ Left)**

Do you have trouble walking in the dark: Yes / No

Medication

Have you taken any medications in the last 48 hours: Yes / No

If so, what: ____

Have you had any alcoholic beverages in the past 48 hours: Yes / No

If so, how much: ____

Vision

When was the last time you had your vision checked: ____

Do you have a vision problem: Yes / No

Do you wear corrective lenses or glasses: Yes / No

Do you have an Ocular Prosthesis: Yes / No

Do you have Congenital Nystagmus: Yes / No

Do you have Macular Degeneration: Yes / No