St. Paul's Hospital Audiology Department

Patient ID

Dizziness/Balance Questionnaire
Cochlear Implant Program

1. Have you ever experienced dizziness/vertigo/imbalance?

☐ NO (NOTE: This form is to be returned even if you have marked "NO")

☐ YES **If "YES", please complete questions 2 to 4.**

2. a. When did the dizziness start?: _____

b. Please describe any severe dizziness episodes you have had. Be sure to include:

- What the dizziness felt like (e.g. spinning, floating, rocking, tilting, drunk, unsteady, etc)
- On average, how long does/did a dizziness episode last?
- Were you nauseated and/or vomiting?
- Did your hearing and/or tinnitus change at the same time?
- How many episodes you have had (approx) or how often they occur?

3. Do you still have dizziness? ☐ **Yes** ☐ **No**

If you answered yes, please complete the questions below:

a. Do you have dizziness when you change positions, e.g. rolling over in bed or lying down? ☐ Yes ☐ No

b. Do loud sounds and/or pressure changes make you dizzy? ☐ Yes ☐ No

c. Do you have dizziness when you strain physically? ☐ Yes ☐ No

d. I have the following medical problems (check all that apply):

☐ motion sickness ☐ migraines ☐ diabetes ☐ I have had a stroke

☐ heart disease ☐ visual problems ☐ anxiety/depression ☐ high/low blood pressure

☐ seizures ☐ neck problems ☐ other _____

4. What medications are you currently taking/or take as needed?