Lawrence Speech & Hearing Services

Vestibular Questionnaire

Patient Name: _____

Current Symptoms:

	Yes	No
Feeling of Motion		
Feeling of Spinning		
Feeling of Turning		
Feeling of Falling		
Lightheadedness		
Faintness		
Wooziness		
Tilting/swaying		
Loss of balance		
Difficulty Walking		
Falling		
Shortness of Breath		
High Pitch Ringing in Ears		

	Yes	No
Headache		
Loss of consciousness		
Weakness of limbs		
Numbness of limbs		
Visual disturbance		
Difficulty with speech		
Heart rate changes		
Popping in Ears		
Fullness in ears		
Pressure in ears		
Hearing Loss		
Nausea		
Low Pitch Ringing in Ears		

When you experience the above symptoms:

Are they sudden? _____

How often do they occur? _____

When do they begin? _____

How long do they last? _____

How are they provoked? _____

Do your symptoms occur more often in certain positions? _____

If yes, what positions? _____

Any other information about your symptoms? _____

_____

_____

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