

Walter Reed Army Medical Center  
Army Audiology and Speech Center  
(202) 782-6643/6644

**Vestibular Evaluation Pre-Test Instructions**

The vestibular evaluation you have scheduled consists of several tests designed to aid in the diagnosis of the underlying cause for your symptoms of dizziness or unsteadiness. All tests and procedures are painless and non-invasive, but may result in some temporary dizziness. You may wish to have someone accompany you to the test in the event the residual dizziness does not go away completely following the test. The testing needed to address your particular symptoms can take approximately 2 hours so please adjust your schedule to accommodate this. Children cannot accompany an adult to this appointment. If you cannot make this appointment, please contact the Audiology Clinic **(202)782-6643/44** as soon as possible so we can use the appointment time for another patient and reschedule your evaluation.

Questionnaire for dizziness evaluation – Audiology Clinic - WRAMC

1. Does looking up increase your problem?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
2. Because of your problem, do you feel frustrated?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
3. Because of your problem, do you restrict your travel for business or recreation?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
4. Does walking down the aisle of a supermarket increase your problem?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
5. Because of your problem, do you have difficulty getting into or out of bed?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No

6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing, or to parties?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
7. Because of your problem, do you have difficulty reading?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
9. Because of your problem, are you afraid to leave your home without having some one accompany you?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
10. Because of your problem, have you been embarrassed in front of others?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
11. Do quick movements of your head increase your problem?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
12. Because of your problem, do you avoid heights?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
13. Does turning over in bed increase your problem?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
14. Because of your problem, is it difficult for you to do strenuous housework or yard work?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
15. Because of your problem, are you afraid people may think you are intoxicated?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
16. Because of your problem, is it difficult for you to walk by yourself?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes

	<input type="checkbox"/> No
17. Does walking down a sidewalk increase your problem?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
18. Because of your problem, is it difficult for you to concentrate?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
19. Because of your problem, is it difficult for you to walk around your house in the dark?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
20. Because of your problem, are you afraid to stay home alone?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
21. Because of your problem, do you feel handicapped?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
22. Has your problem placed stress on your relationships with members of your family or friends?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
23. Because of your problem, are you depressed?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
24. Does your problem interfere with your job or household responsibilities?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
25. Does bending over increase your problem?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
DHI - Developed by Dr. G.P. Jacobson and Dr. C.W. Newman, 1990.	