

A PATIENT'S HANDBOOK

What's Wrong With My Ears?

A plain-language handbook on tinnitus, vertigo, dizziness, and balance — what each one is, what causes them, when to worry, and what to track at home before your next doctor's visit.

Inside this guide

- 4 symptoms decoded clearly
- The Big Five vertigo causes
- Red-flag emergency checklist
- Universal home tracking template



Free companion resource
by **Meniere's: Symptom Tracker**

Four symptoms, one address — but four different problems

"Doctor, I'm just... dizzy."

It is the single most common — and least useful — sentence in any neurology or ENT clinic. Tinnitus, vertigo, dizziness, and balance trouble share an address (the inner ear and the parts of the brain it talks to) but they are not the same thing, they don't share the same causes, and they don't respond to the same treatments. Patients spend years bouncing between specialists because the language is too imprecise to point at a diagnosis.

What this handbook does

- 1. **Decodes the four symptoms** — what each one actually is, what causes it, and what helps. In plain language, with the medical terms in parentheses so you can search them later.
- 2. **Tells you what's an emergency and what isn't** — a single red-flag checklist that covers all four symptoms.
- 3. **Gives you a universal home-tracking template** — nine fields that turn a vague 15-minute clinic visit into a productive one.
- 4. **Matches your symptom to the right specialist** — so you stop wasting referrals.

Quick reference: the four symptoms at a glance

Symptom	What it actually is
Tinnitus	Sound (ringing, buzzing, roaring, clicking) without an external source. A symptom, not a disease — usually chronic and benign, occasionally points to something treatable.
Vertigo	A false sensation of motion, usually spinning. Either you feel like you're moving when you're not, or the world feels like it's moving when it's not. A signal that something is wrong with the balance system.
Dizziness	An umbrella word for lightheadedness, unsteadiness, "wooziness," or feeling faint. <i>Not</i> the same as vertigo. Most dizziness has nothing to do with the inner ear.
Balance trouble	Difficulty staying upright or walking steadily. Comes from the integration of vision, the inner ear, and proprioception. When any one of those three goes wrong, balance suffers.

Not medical advice. This handbook is educational and draws on AAO-HNS clinical practice guidelines, the Bárány Society International Classification of Vestibular Disorders, and standard neurotology texts. Only a clinician can diagnose any of the conditions described here. If a symptom is sudden, severe, or paired with neurological warning signs, treat it as urgent.

Tinnitus — sound without a source

Tinnitus is the perception of sound that has no external source. Ringing, buzzing, hissing, humming, roaring, clicking, or pulsing. One ear, both ears, or "inside the head." About **10–15% of adults** live with persistent tinnitus; roughly **1–2%** describe it as severe enough to disrupt daily life. It is one of the most common ENT complaints — and one of the most under-treated.

Two distinctions that change everything

Subjective (≈99%)

- Only the patient hears it.
- Usually downstream of cochlear hair-cell damage.
- Most common subtype.

Objective (rare)

- A clinician can sometimes hear it with a stethoscope.
- Usually vascular or muscular in origin.
- More likely to point to a specific treatable cause.

Pulsatile vs non-pulsatile matters because the workup is different. Pulsatile tinnitus is rhythmic and matches the pulse; it always deserves careful evaluation because it can occasionally be caused by vascular abnormalities (narrowed arteries, AV malformations, dural fistulas, idiopathic intracranial hypertension, or glomus tumors).

Common causes

Noise-induced hearing loss — the single biggest cause. Years of concerts, headphones, machinery, gunfire.

Age-related hearing loss — tracks the high-frequency loss that begins around age 50–60.

Ototoxic medications — high-dose aspirin/NSAIDs, loop diuretics, cisplatin, IV aminoglycosides. Sometimes reversible.

Meniere's disease — characteristically low-pitched, "rumbling" tinnitus that fluctuates with attacks, paired with ear fullness.

Acoustic neuroma — benign tumor on the hearing/balance nerve. Suspect when tinnitus + hearing loss are clearly one-sided. Rule out with MRI.

TMJ dysfunction, neck problems, earwax impaction, middle-ear disease — common, often fixable.

Modulators (not causes) — stress, anxiety, poor sleep, caffeine, nicotine. They make existing tinnitus louder.

What the evidence actually supports

- **Hearing aids** for anyone with concurrent hearing loss — often reduce tinnitus distress by 50%+ on their own.
- **Cognitive Behavioral Therapy (CBT)** — strongest evidence base. Doesn't reduce loudness; dramatically reduces distress and sleep disruption.
- **Sound therapy** — low-level background noise reduces the contrast between tinnitus and silence.
- **What does NOT help:** ginkgo biloba, melatonin (for tinnitus itself), zinc, lipoflavonoid supplements, any "tinnitus cure" sold online.

Red flags — treat as urgent: sudden one-sided tinnitus with sudden hearing loss · pulsatile tinnitus · tinnitus with new neurological symptoms · progressive one-sided hearing loss (needs MRI).

Vertigo — a false sensation of motion

Vertigo is **not** a synonym for "dizzy." It is a specific perception: the room spins, you feel like you are spinning, you feel like you are tilting or being pulled to one side. If you do not feel motion that isn't happening, you don't have vertigo — you have something else (covered in the next section), and that something else has different causes.

Vertigo almost always means something is wrong with the **vestibular system** — the inner ear's balance organs (semicircular canals and otolith organs), the vestibular nerve, or the parts of the brainstem and cerebellum that process balance signals.

The Big Five vertigo causes (≈ 90% of cases)

BPPV (Benign Paroxysmal Positional Vertigo) — tiny calcium crystals dislodge into a semicircular canal. Brief, intense spinning lasting **seconds to under a minute** when you roll over in bed, look up, or bend forward. Diagnosed with the Dix-Hallpike maneuver. The Epley maneuver cures it in 1–2 sessions for most patients — one of the most effective treatments in all of medicine.

Meniere's disease — chronic disorder of inner-ear fluid pressure. Spontaneous attacks of **20 minutes to several hours**, with hearing change, tinnitus, and ear fullness on the affected side. Treatment: low-sodium diet, diuretics, vestibular rehab, intratympanic steroids in refractory cases.

Vestibular neuritis (and labyrinthitis) — inflammation of the vestibular nerve, usually post-viral. A single severe episode lasting **days**, often with nausea bad enough to need IV fluids. Treatment: short course of corticosteroids in the first 1–3 days, then early vestibular rehabilitation. The earlier you start moving, the faster the brain compensates.

Vestibular migraine — migraine where vertigo dominates, with or without headache. Episodes **5 minutes to 72 hours**, often with light/sound sensitivity, nausea, or visual aura. Patient typically has personal or family history of migraine. Treatment: migraine prophylaxis — *not* a low-sodium diet.

Central causes (small but important) — stroke or TIA in brainstem/cerebellum can mimic peripheral vertigo. Multiple sclerosis can cause vertigo as a relapse. Acoustic neuroma usually presents with one-sided hearing loss and tinnitus more than rotational vertigo.

The critical question — peripheral or central?

This is what every emergency clinician is trying to answer when you arrive with vertigo.

Peripheral (inner ear)

- Spinning often dominant.
- Hearing or tinnitus changes possible.
- Position-triggered.
- Severe nausea.
- **No other neurological symptoms.**

Central (brain) — emergency

- Vertigo + facial droop, slurred speech, double vision.
- New severe headache.
- Limb weakness or numbness.
- Severe imbalance (can't sit up).
- Vertical nystagmus.

Dizziness — the umbrella word

"Dizzy" is to medicine what "stomach pain" is — too vague to be diagnostic. The first job of a clinician hearing the word is to figure out which of four very different sensations the patient actually means. Get this right and the workup is short. Get it wrong and you spend years on the wrong specialist circuit.

The four flavors of dizziness

Vertigo — false sensation of motion (covered in Section 2). Inner ear or brain.

Pre-syncope (lightheadedness) — feeling like you might pass out. Often with tunnel vision, ringing, sweating. Almost always a circulation problem: the brain is briefly under-perfused.

Disequilibrium — feeling unsteady on your feet without spinning, especially when standing or walking. Usually a balance-system problem, not an inner-ear attack.

Non-specific dizziness — "wooziness," "foggy," "off." Often anxiety-related, sometimes medication-related, sometimes Persistent Postural-Perceptual Dizziness (PPPD).

Common causes of non-vertigo dizziness

Orthostatic hypotension — BP drops when you stand. Common in older adults, dehydration, and BP medications. Confirm with lying-then-standing BP at 1 and 3 minutes.

Vasovagal pre-syncope — triggered by pain, stress, prolonged standing, heat, sight of blood. Very common, benign, unsettling.

Cardiac arrhythmias — new "dizzy spells" without an obvious pattern in older adults or anyone with heart disease deserve a cardiac workup.

Hypoglycemia, anemia, medication side effects — easy to screen for and often the answer. Always review the medication list first.

Anxiety and panic — hyperventilation drops CO₂, constricts cerebral arteries, dizziness fuels more anxiety. Recognizable loop.

Persistent Postural-Perceptual Dizziness (PPPD) — chronic functional disorder, often after an acute vestibular event. The brain stays in heightened motion sensitivity. Treated with vestibular rehab, SSRIs, CBT.

Cervicogenic dizziness — from neck dysfunction. Real but often over-diagnosed; a diagnosis of exclusion.

Better than "I feel dizzy": "I feel like I'm about to faint" / "the room is spinning" / "unsteady on my feet" / "foggy and off." Each sends the workup in a different direction.

Balance — a real-time integration problem

Standing upright is harder than it looks. Your brain takes three input streams and continuously calculates where your center of mass is and what to do about it.

Vision — high-resolution map of where the world is and where you are within it. Close your eyes in the shower and balance gets noticeably harder; this is the source of most "I can't balance with my eyes closed" moments.

Vestibular system — three semicircular canals (rotational acceleration in three planes) and two otolith organs (linear acceleration and gravity) in each inner ear. Tells the brain which way is up.

Proprioception — sensors in joints, muscles, and especially the soles of your feet, telling the brain where your body is and how the ground is angled.

The brain can lose *any one* of these three inputs and still balance. **Lose two at once and balance falls apart.** This is why an older person on a thick carpet (degraded proprioception) in dim light (degraded vision) is at high fall risk even with a perfectly normal vestibular system.

Common balance disorders

Bilateral vestibular hypofunction — both inner ears underperform (often post-gentamicin or autoimmune). Patients describe "oscillopsia" — the world bouncing when walking. They fall in the dark.

Cerebellar disorders — wide-based, lurching gait. Stroke, alcohol-related degeneration, hereditary ataxias.

Peripheral neuropathy — diabetes, B12 deficiency, chemotherapy, alcohol. Loss of foot sensation degrades proprioception.

Visual problems — uncorrected refractive error, cataracts, multifocal lenses (the bottom of a progressive lens distorts where your feet are).

Sarcopenia, deconditioning, polypharmacy — adults lose 1–2% muscle mass per year after 60. Sedatives, opioids, BP meds, alcohol all impair balance.

Fall prevention that actually works

One in three adults over 65 falls each year. Falls are the leading cause of injury-related death in older adults. Balance is not a cosmetic concern.

- **Strength + balance training** — 2–3 sessions/week. Tai chi has the strongest evidence; gaze-stabilization and single-leg stance progressions also work.
- **Vision + medication review** — annual eye exam, treat cataracts, review every drug for balance impact.
- **Home hazard sweep** — lose loose rugs, add bathroom grab bars, light the night-time path to the bathroom.
- **Vitamin D** — correct deficiency. Supplementation helps deficient adults only — test before supplementing.

6 balance exercises — for the fridge

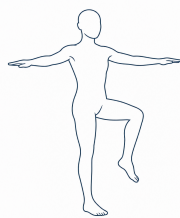
Print this page and put it where you'll see it daily. Aim for **2–3 sessions a week**, holding each balance position for 30 seconds (or as long as you can safely). The first few weeks, stand near a wall or sturdy chair — the goal is to challenge your balance without falling. Get cleared by your doctor first if you have had a recent fall, vestibular event, or other balance disorder.



1

Tandem stance **HOLD 30S × 3 / EACH SIDE**

Stand heel-to-toe in a straight line. Look forward at a fixed point. Switch which foot is in front each round.



2

Single-leg stance **HOLD 30S × 2 / EACH LEG**

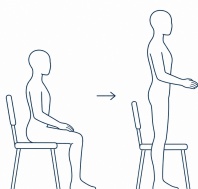
Stand on one leg, the other knee slightly bent and lifted. Once steady, progress to eyes closed.



3

Heel raises **10 REPS × 2 SETS**

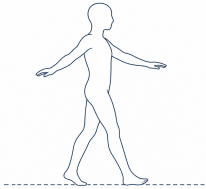
Slowly rise onto your toes, hold 2 seconds, lower with control. Builds calf strength for stable walking.



4

Sit-to-stand **10 REPS × 2 SETS**

From a sturdy chair, stand up without using your hands. Sit back down with control. Best functional leg-strength move.



5

Tandem walk **10 STEPS × 3**

Walk in a straight line placing each foot directly in front of the other (heel to toe). Use a hallway wall for safety.



6

Marching in place **30 SECONDS × 2**

Lift one knee toward your chest, lower it; alternate. Keep posture tall. Trains balance during dynamic weight shifts.

Safety: Always practice within reach of a wall, counter, or sturdy chair the first few weeks. Stop if you feel dizziness, lightheadedness, or sharp pain. Don't practice on a plush rug or uneven surface until you're confident on a flat floor. Build up gradually — consistency beats intensity for balance.

The single red-flag checklist

For all four symptoms in this handbook, the same situations turn a routine clinic visit into an emergency. Print this page, share it with anyone who lives with you.

Go to the emergency room (or call emergency services) if any of these accompany dizziness, vertigo, tinnitus, or imbalance:

- Sudden severe headache, especially unlike any you have had before.
- New facial droop, weakness, or numbness on one side of the body.
- Slurred speech or trouble understanding speech.
- Double vision, vision loss, or vertical eye-jerk movements.
- Trouble swallowing.
- Vertigo so severe you cannot sit upright.
- **Sudden hearing loss**, especially in one ear — the treatment window for sudden sensorineural hearing loss is days, not weeks.
- Vertigo with chest pain, palpitations, or shortness of breath.
- First-ever severe vertigo episode in someone with vascular risk factors (older adult, smoker, hypertension, diabetes, atrial fibrillation).
- Confusion or loss of consciousness.

What to track at home — the universal template

Whether your symptom is tinnitus, vertigo, dizziness, or balance, clinicians want roughly the same data. Filling this in for 2–4 weeks before an appointment will make a 15-minute visit dramatically more productive than describing things from memory.

- 1 What did you feel?** Use specific words: spinning, lightheaded, woozy, unsteady, ringing, fullness, hearing change. Avoid "dizzy" alone.
- 2 When did it start?** Time of day, what you were doing.
- 3 How long did it last?** Seconds, minutes, hours, days.
- 4 What triggered it?** Position change, standing up, food, lack of sleep, stress, exercise, weather, menstrual cycle phase.
- 5 Was hearing or tinnitus involved?** Which ear, how it changed.
- 6 Other symptoms?** Headache, light/sound sensitivity, nausea, sweating, palpitations, visual aura.
- 7 How severe?** 1–10 scale, and how disabling — could you function, did you have to lie down.
- 8 What helped?** Lying still, dark room, sleep, medication, eating, drinking water, anti-nausea drug.
- 9 Recovery** — back to baseline immediately, an hour later, the next day, or did residual unsteadiness last days?

Two to four weeks of these entries gives a specialist enough to decide which condition is most likely and which test (audiogram, Dix-Hallpike, video head impulse test, MRI, tilt-table) is worth running first. It is the single highest-leverage thing a patient can do between symptom onset and appointment.

Which doctor for which symptom

Most referrals fail because the symptom is sent to the wrong specialty. Use this table before you book.

Specialist	When to choose them
Otolaryngologist (ENT)	First stop for any inner-ear or hearing-related symptom. Audiometry, basic vestibular testing, ear exam.
Neurotologist / otoneurologist	ENT subspecialty focused entirely on inner-ear and balance disorders. The right specialist for Meniere's, suspected acoustic neuroma, complex vertigo, or anyone whose first ENT couldn't explain things.
Neurologist	For suspected vestibular migraine, central causes, MS, or any vertigo with neurological symptoms.
Vestibular physical therapist	Under-used and remarkably effective. Performs Epley maneuvers for BPPV, designs vestibular rehab programs after vestibular neuritis, treats PPPD. Often more available than a neurotologist.
Cardiologist	If dizziness is pre-syncope, syncope, or paired with palpitations or chest symptoms.
Audiologist	For hearing aids and tinnitus management programs.

How to make the most of your specialist visit

- Bring your symptom log printed or on your phone — written, not from memory.
- Bring a list of every medication and supplement you take, with doses.
- Bring prior test results — old audiograms, MRI reports, tilt-table results.
- Write down your top three questions before the visit. Ask them first.
- If something is unclear, ask the clinician to write down the working diagnosis and the next step. Memory after a 15-minute visit is unreliable.
- If hearing is part of your picture, insist on an audiogram — it is fast, painless, and one of the most informative tests in the entire vestibular workup.

Bring the data, not the complaint. "I had 3 vertigo episodes this month, all lasting 30 minutes to 2 hours, all preceded by left-ear fullness, all with tinnitus that got louder for an hour beforehand" lands differently than "I've been dizzy a lot lately." Your tracking exists to make that first sentence possible.

Why paper symptom logs stop working around day 14

The universal tracking template on page 8 works. The specialist-matching table on page 9 works. But here's the uncomfortable reality: **most people quit paper tracking between day 10 and day 16**. Not because they're lazy — because manual tracking asks you to do three things at once:

1. Remember to log, every day, including bad days when you feel awful.
2. Write down data that doesn't feel useful yet, for weeks.
3. Spot cross-variable patterns across 30 rows of handwriting with no chart.

All three fail in the same places. Here's the honest comparison:

Paper journal

- Relies on memory — you'll miss 30% of entries by week 2.
- No weather data unless you look it up manually.
- Can't spot combination triggers without a spreadsheet.
- Your doctor gets a messy stack of pages.
- No reminders when you forget to log.
- Great for days 1–10. Falls apart after that.

An app built for this

- Automatic barometric pressure and weather capture on every entry.
- Streaks and daily reminders that keep you logging.
- Pattern detection across sleep, stress, diet, hearing, and weather.
- Exportable doctor report — single PDF with charts.
- Symptom history you can actually search.
- Insights that update as you add more data.

This is why we built Meniere's: Symptom Tracker. Although the app is named for Meniere's disease, the logging engine works for anyone with vertigo, tinnitus, balance trouble, or recurring dizziness — every field in the universal template on page 8 is captured automatically, plus barometric pressure and a doctor-ready PDF export. Free to try, and this handbook works whether or not you use it.



THE COMPANION APP FOR THIS HANDBOOK

Meniere's: Symptom Tracker

Every field in the universal tracking template, automated. Log in 20 seconds a day. Export a clinician-ready PDF in one tap — for any vestibular, hearing, or dizziness workup.

Automatic pressure tracking

Barometric + weather context on every entry — no manual lookup.

Pattern insights

Surfaces the symptom triggers and clusters that actually matter for you.

Doctor-ready PDF export

One tap. Charts, attack history, trigger summary. Walk in prepared.

Streaks that keep you honest

Daily reminders, gentle nudges. Solves the "day 14 dropout" problem.



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