



# VESTIBULAR

## DISORDERS ASSOCIATION

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### Dizziness & Balance Medical History Questionnaire

Complete this questionnaire and bring it with you when you visit your physician. You may want to reference your previous medical history records and/or ask a friend or family member familiar with your condition to help you.

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

#### I. DIZZINESS SYMPTOMS

Check all that apply (In the space after each symptom you check, rate the severity of that symptom using a scale of 0-10, with 10 being most severe.)

✓	Symptom	1-10	✓	Symptom	1-10	✓	Symptom	1-10	✓	Symptom	1-10
	Dizziness			Spinning			Lightheadedness			Rocking/tilting	
	Visual changes			Tumbling			Cart wheeling			Unsteadiness	
	Falling			Ringing in ears			Fullness in ears			Fainting	
	Hearing loss			Double vision			Brain fog			Other:	

#### II. HISTORY OF PRESENT ILLNESS

##### a. Describe your current problem:

- i. When did your problem start (date)? \_\_\_\_\_
- ii. Was it associated with a related event (e.g. head injury)?  Yes  No  
If yes, please explain: \_\_\_\_\_
- iii. Was the onset of your symptoms:  sudden  gradual  overnight  other (describe): \_\_\_\_\_
- iv. Are your symptoms:  constant  variable (i.e. come and go in attacks)
  - If variable:
    - a. The spells occur every (# of): \_\_\_\_\_ hours \_\_\_\_\_ days \_\_\_\_\_ weeks \_\_\_\_\_ months \_\_\_\_\_ years.
    - b. The spells last:  < 1 min.  1-2 min.  3-10 min.  11-30 min.  ½-1 hr.  2-6 hrs.  7-24 hrs.  > 24 hrs.
    - c. Do you have any warning signs that an attack is about to happen?  yes  no  
If yes, please describe: \_\_\_\_\_
    - d. Are you completely free of symptoms between attacks?  yes  no
- v. Do your symptoms occur when changing positions?  yes  no  
If yes, check all that apply:

✓	Symptom	✓	Symptom
	Rolling your body to the left		Rolling your body to the right
	Moving from a lying to a sitting position		Looking up with your head back
	Turning head side to side while sitting/standing		Bending over with your head down

- vi. Is there anything that makes your symptoms better?  yes  no  
If yes, please explain: \_\_\_\_\_

vii. Is there anything that makes your symptoms worse?  yes  no

If yes, check all that apply:

<input type="checkbox"/> ✓	Symptoms	<input type="checkbox"/> ✓	Symptoms
<input type="checkbox"/>	Moving my head	<input type="checkbox"/>	Physical activity or exercise
<input type="checkbox"/>	Riding or driving in the car	<input type="checkbox"/>	Large crowds or a busy environment
<input type="checkbox"/>	Loud sounds	<input type="checkbox"/>	Coughing, blowing the nose, or straining
<input type="checkbox"/>	Standing up	<input type="checkbox"/>	Eating certain foods
<input type="checkbox"/>	Time of day	<input type="checkbox"/>	Menstrual periods (if applicable)
<input type="checkbox"/>	Other:	<input type="checkbox"/>	Other:

viii. Do you have difficulty walking in the dark or at dusk?  yes  no

ix. When you have symptoms, do you need to support yourself to stand or walk?

yes  no

If yes, how do you support yourself? \_\_\_\_\_

x. Do you have difficulty walking on uneven surfaces (e.g. grass or gravel) compared with smooth surfaces (e.g. concrete)?  yes  no

xi. Have you ever fallen as a result of your current problem?  yes  no

xii. Do you have a history of:

<input type="checkbox"/> ✓	Symptom	<input type="checkbox"/> ✓	Symptom	<input type="checkbox"/> ✓	Symptom	<input type="checkbox"/> ✓	Symptom
<input type="checkbox"/>	Migraines	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Tumor	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	MS	<input type="checkbox"/>	Neuropathy	<input type="checkbox"/>	Panic attacks	<input type="checkbox"/>	Congestive heart failure
<input type="checkbox"/>	Concussion	<input type="checkbox"/>	Depression	<input type="checkbox"/>		<input type="checkbox"/>	

xiii. Has there been a recent change in your vision, including contacts or glasses?

yes  no Explain: \_\_\_\_\_

**b. Describe any ear related symptoms:**

i. Do you have difficulty with hearing?  yes  no

If yes, which ear(s):  left  right  both

When did this start? \_\_\_\_\_

ii. Do you wear hearing aids?  yes  no

If yes, which ear(s):  left  right  both

iii. Do you experience noise or ringing in your ears?  yes  no

If yes, which ear(s):  left  right  both

➤ Describe the noise:  ringing  buzzing  whoosing  other: \_\_\_\_\_

➤ Does the noise pulsate or is it steady?  steady  pulsate  variable

➤ Does anything stop the noise or make it better?  yes  no

If yes, explain: \_\_\_\_\_

iv. Do you have pain, fullness, or pressure in your ears?  yes  no

v. Do your ear symptoms occur at the same time as your dizziness/imbalance symptoms?

yes  no

**c. When dizzy or imbalanced, do you experience any of the following:**

i. Lightheadedness or a floating sensation?  yes  no

ii. Objects or your environment turning around you?  yes  no

iii. A sensation that you are turning or spinning while the environment remains stable?

yes  no

iv. Nausea or vomiting?  yes  no

v. Tingling of hands, feet or lips?  yes  no

vi. When you are walking, do you:  veer left?  veer right?  remain in a straight path?

**d. Prior relevant medical evaluations, diagnostic testing, and treatment:**

i. Have you seen other healthcare providers for your current condition?  yes  no

If yes, who:  primary care doctor  ENT/HNS doctor  neurologist  cardiologist

Emergency room doctor  Other: \_\_\_\_\_

ii. Have you had any of the following done for this condition elsewhere?

✓	Test/ Therapy	When	Where	Results
	ENG/VNG			
	CT Scan			
	Hearing test			
	Physical therapy			Did it help? <input type="checkbox"/> yes <input type="checkbox"/> no
	Occupational therapy			

### III. SOCIAL HISTORY/ LIFESTYLE

**a. Please describe your current work status:**

full-time  part-time  unemployed  disabled  retired

Occupation (if applicable): \_\_\_\_\_

**b. Please indicate your level of activity currently and prior to developing symptoms:**

i. Current activity level:  inactive  light  moderate  vigorous

List activities/hobbies: \_\_\_\_\_

ii. Prior activity level:  inactive  light  moderate  vigorous

List activities/hobbies: \_\_\_\_\_

iii. If your activity is light or inactive, what are the major barriers? (check all that apply)

dizziness  imbalance  fear of falling  lack of energy  other: \_\_\_\_\_

### IV. HABITS

**a. Please describe your habits in regards to the following substances:**

i. Caffeine

I do not consume caffeine.

I consume caffeine.

I drink \_\_\_\_\_ (#) cups of \_\_\_\_\_ (e.g. coffee) per  day  week  month

ii. Tobacco

I do not consume tobacco.

I consume tobacco.

I smoke/chew \_\_\_\_\_ (#) of \_\_\_\_\_ (product) per  day  week  month

iii. Alcohol

I do not consume alcohol.

I consume alcohol.

I drink \_\_\_\_\_ (#) glasses of \_\_\_\_\_ (e.g. wine) per  day  week  month

iv. Recreational drug use

I do not use drugs.

I use \_\_\_\_\_.

How many times/day? \_\_\_\_\_ For how many years? \_\_\_\_\_

v. Medications

I do not take any medications.

I take the following medications:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_