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.

Patient Name: _____ DOB: _____ Date: _____

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			Nausea			Unsteadiness	
	Falling			Ringing in ears			Fullness in ears			Fainting	
	Hearing loss			Double vision			Brain fog			Other:	

HISTORY OF PRESENT ILLNESS

1) Describe your current problem:
   a. When did your problem start (date)? _____
   b. Was the onset of your symptoms: ☐ sudden ☐ gradual ☐ overnight ☐ other (describe): _____
   c. Are your symptoms: ☐ constant ☐ variable (i.e. come and go in attacks)
   d. If variable:
      i. The spells occur every (# of): _____ hours _____ days _____weeks _____ months _____ years.
      ii. The spells last: ☐ < 1 min. ☐ 1-60 min. ☐ 1-3 hrs. ☐ 3-24 hrs. ☐ 1-3 days
   e. Do your symptoms occur when changing positions? ☐ yes ☐ no
      i. 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

   f. Is there anything that makes your symptoms worse? ☐ yes ☐ no
      i. If yes, check all that apply:

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

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

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

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

j. Do you have a history of:

✓	**Symptom**	✓	**Symptom**	✓	**Symptom**	✓	**Symptom**
	Migraines		Seizures		Tumor		Stroke
	MS		Neuropathy		Panic attacks		Congestive heart failure
	Concussion		Depression				

2) Describe any ear related symptoms:

a. Do you have difficulty with hearing? ☐ yes ☐ no

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

ii. When did this start? _____

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

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

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

d. Do your ear symptoms occur at the same time as your dizziness/imbalance symptoms? ☐ yes ☐ no

3) When dizzy or imbalanced, do you experience any of the following:

a. Lightheadedness or a floating sensation? ☐ yes ☐ no

b. Objects or your environment turning around you? ☐ yes ☐ no

c. A sensation that <u>you</u> are turning or spinning while the environment remains stable? ☐ yes ☐ no

d. Nausea or vomiting? ☐ yes ☐ no

e. Tingling of hands, feet or lips? ☐ yes ☐ no

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

DIAGNOSTIC TESTING AND TREATMENT:

1) Have you seen other healthcare providers for your current condition? ☐ yes ☐ no

a. If yes, who: ☐ primary care doctor ☐ENT/HNS doctor ☐ neurologist ☐ cardiologist ☐ Emergency room doctor ☐ Other: _____

2) Have you had any of the following done for this condition elsewhere?

✓	**Test/Therapy**	**When**	**Where**	**Results**
	ENG/VNG			
	CT Scan			
	MRI			
	Posturography			
	Hearing test			
	Physical therapy			Did it help? ☐ yes ☐ no
	Occupational therapy			Did it help? ☐ yes ☐ no
	Canalith Repositioning			Did it help? ☐ yes ☐ no

Is there anything else that you feel is relevant to your condition?

_____

_____