VESTIBULAR DISORDERS ASSOCIATION

5018 NE 15TH AVE · PORTLAND, OR 97211 · FAX: (503) 229-8064 · (800) 837-8428 · INFO@VESTIBULAR.ORG · VESTIBULAR.ORG

Vestibular Patient Health Record Enclosure

Patient Name: _____ **Date**: _____

Please add this document to my permanent medical record. I would like to discuss this with my medical provider during my next scheduled visit.

I HAVE A VESTIBULAR DISORDER or EXPERIENCE SYMPTOMS RELATED TO A VESTIBULAR DISORDER.

Diagnosis: _____ (confirmed/not confirmed)

Symptoms (circle all that apply): dizziness, imbalance, vertigo, tinnitus, hearing loss, problems concentrating, nausea, vision disturbances, headaches, anxiety, depression.

Other symptoms: _____

_____

_____

_____

_____

I have problems with (circle all that apply): lying flat, hearing, understanding complex medical jargon, short-term memory.

Other (list things that will help your healthcare provider during your visit): _____

_____

_____

_____

_____

_____

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I would like my healthcare provider's help with: _____

_____

_____

_____

_____

_____

Medications I am taking: _____

_____

_____

_____

Prior treatment/tests related to my vestibular condition: _____

_____

_____

_____

_____

_____

_____

_____

Resources (attached): I have attached publications from the Vestibular Disorders Association (VEDA) that describe my condition.

Other specialists/healthcare providers I have seen/am seeing about this condition (list provider's name and specialty):

1. _____
2. _____
3. _____
4. _____