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): ____________________

____

____

____

____

____

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

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. ______________________________________