DIZZINESS & BALANCE MEDICAL HISTORY QUESTIONNAIRE

Complete this questionnaire and bring it with you when you visit your physician, physical therapist, or other medical practitioner. 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: ____________________

Name: __________________________________ Date of Birth: ____________________

I. INITIAL ONSET
Describe what happened the first time you experienced dizzy/imbalanced symptoms:

II. 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.)

<table>
<thead>
<tr>
<th>✓</th>
<th>Symptom</th>
<th>1-10</th>
<th>✓</th>
<th>Symptom</th>
<th>1-10</th>
<th>✓</th>
<th>Symptom</th>
<th>1-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>Dizziness</td>
<td></td>
<td>✓</td>
<td>Spinning</td>
<td></td>
<td>✓</td>
<td>Lightheadedness</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Headache</td>
<td></td>
<td></td>
<td>Fatigue</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Noise in ears</td>
<td></td>
<td></td>
<td>Brain fog</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Double vision</td>
<td></td>
<td></td>
<td>Fullness, pressure, or pain in ears</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Other:</td>
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</tr>
</tbody>
</table>

III. 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 spells)  
   ☦ If variable:
   a. The spells occur every (# of): _______ hours _______ days _______ weeks _______ months _______ years.
   b. The spells last: ☐ seconds ☐ minutes ☐ hours ☐ days  
   c. Do you have any warning signs that a spell is about to happen? ☐ yes ☐ no  
      If yes, please describe: __________________________________________
   d. Are you completely free of symptoms between spells? ☐ yes ☐ no

v. Do your symptoms occur when changing positions? ☐ yes ☐ no  
   If yes, check all that apply:

<table>
<thead>
<tr>
<th>☐ Position</th>
<th>☐ Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rolling your body to the left</td>
<td>Rolling your body to the right</td>
</tr>
<tr>
<td>Moving from a lying to a sitting position</td>
<td>Looking up with your head back</td>
</tr>
<tr>
<td>Turning head side to side while sitting/standing</td>
<td>Bending over with your head down</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>☐ Activity/Situation</th>
<th>☐ Activity/Situation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moving my head</td>
<td>Physical activity or exercise</td>
</tr>
<tr>
<td>Riding or driving in the car</td>
<td>Large crowds or a busy environment</td>
</tr>
<tr>
<td>Loud sounds</td>
<td>Coughing, blowing the nose, or straining</td>
</tr>
<tr>
<td>Standing up</td>
<td>Eating certain foods</td>
</tr>
<tr>
<td>Time of day</td>
<td>Menstrual periods (if applicable)</td>
</tr>
<tr>
<td>Stress</td>
<td>Other:</td>
</tr>
</tbody>
</table>

viii. When you have symptoms, do you need to support yourself to stand or walk?  
    ☐ yes ☐ no  
    If yes, how do you support yourself? ______________________________________

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

x. Do you have a history of:

<table>
<thead>
<tr>
<th>☐ Diagnosis</th>
<th>☐ Diagnosis</th>
<th>☐ Diagnosis</th>
<th>☐ Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Migraines</td>
<td>Seizures</td>
<td>Tumor</td>
<td>Stroke</td>
</tr>
<tr>
<td>Multiple Sclerosis</td>
<td>Neuropathy</td>
<td>Panic attacks/Anxiety</td>
<td>Congestive heart failure</td>
</tr>
<tr>
<td>Concussion</td>
<td>Depression</td>
<td>Cervical Spine Arthritis</td>
<td>Diabetes Mellitus</td>
</tr>
<tr>
<td>Glaucoma</td>
<td>Macular Degeneration</td>
<td>Parkinson's Disease</td>
<td>Ataxia</td>
</tr>
</tbody>
</table>

xi. 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 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:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lightheadedness or a floating sensation?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Objects or your environment turning around you?

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

Nausea or vomiting?

Tingling in your hands, feet or lips?

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?

<table>
<thead>
<tr>
<th>Test/Therapy</th>
<th>When</th>
<th>Where</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENG/VNG</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>CT Scan or MRI</td>
<td></td>
<td></td>
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<tr>
<td>Hearing test</td>
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<td></td>
<td></td>
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<tr>
<td>Rehabilitation (PT or OT)</td>
<td></td>
<td></td>
<td>Did it help? □ yes □ no</td>
</tr>
</tbody>
</table>

**IV. ADDITIONAL INFORMATION**

Is there anything else you would like to make sure to tell your physician about?
**OPTIONAL QUESTIONS:** The following questions are not necessary to determine a diagnosis, but may be helpful in formulating a treatment plan.

V. 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: ________________

VI. 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. Meclizine [ ] yes [ ] no
         2. Ativan [ ] yes [ ] no
         3. Hydrochlorothiazide [ ] yes [ ] no
         4. Other: _____________________________
         5. Other: _____________________________
         6. Other: _____________________________

Special Note: This form is provided as a means to help you gather information on your medical history and current symptoms while you have time and resources to do so completely and accurately, and with assistance, if necessary. Some physicians may have their own intake form they want you to fill out. If so, you may use this form as a reference. If there is information on this form that your physician does not ask you, you may want to bring it to their attention, as it may help them to more accurately diagnose your condition.