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>
<th>✓</th>
<th>Symptom</th>
<th>1-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>Dizziness</td>
<td>Spinning</td>
<td></td>
<td>Lightheadedness</td>
<td>Rocking/tilting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓</td>
<td>Visual changes</td>
<td>Headache</td>
<td></td>
<td>Fatigue</td>
<td>Unsteadiness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>✓</td>
<td>Falling</td>
<td>Noise in ears</td>
<td></td>
<td>Brain fog</td>
<td>Fainting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hearing loss</td>
<td>Double vision</td>
<td></td>
<td>Fullness, pressure, or pain in ears</td>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</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:
       √ Position
          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:
       √ Activity/Situation
          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)
          Stress
          Other:
   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:
      ✓ Diagnosis
        Migraines
        Multiple Sclerosis
        Concussion
        Glaucoma
      ✓ Diagnosis
        Seizures
        Neuropathy
        Depression
        Macular Degeneration
      ✓ Diagnosis
        Tumor
        Panic attacks/Anxiety
        Cervical Spine Arthritis
        Parkinson’s Disease
      ✓ Diagnosis
        Stroke
        Congestive heart failure
        Diabetes Mellitus
        Ataxia
   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>
<tr>
<td>Objects or your environment turning around you?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A sensation that you are turning or spinning while the environment remains stable?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea or vomiting?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tingling in your hands, feet or lips?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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>
</tr>
<tr>
<td>CT Scan or MRI</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing test</td>
<td></td>
<td></td>
<td></td>
</tr>
<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.
      If you consume caffeine, I drink _______ (#) cups of ____________________________ (e.g. coffee) per [ ] day [ ] week [ ] month
   ii. Tobacco
      - [ ] I do not consume tobacco.
      - [ ] I consume tobacco.
      If you consume tobacco, I smoke/chew _______ (#) of ____________________________ (product) per [ ] day [ ] week [ ] month
   iii. Alcohol
      - [ ] I do not consume alcohol.
      - [ ] I consume alcohol.
      If you 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.