



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): _____

VESTIBULAR DISORDERS ASSOCIATION

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. _____

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