VESTIBULAR DISORDERS ASSOCIATION

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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.)*

✓	Symptom	1-10	✓	Symptom	1-10	✓	Symptom	1-10	✓	Symptom	1-10
	Dizziness			Spinning			Lightheadedness			Rocking/tilting	
	Visual changes			Headache			Fatigue			Unsteadiness	
	Falling			Noise in ears			Brain fog			Fainting	
	Hearing loss			Double vision			Fullness, pressure, or pain in ears			Other:	

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	√	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	√	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	✓	Diagnosis	✓	Diagnosis	✓	Diagnosis
	Migraines		Seizures		Tumor		Stroke
	Multiple Sclerosis		Neuropathy		Panic attacks/Anxiety		Congestive heart failure
	Concussion		Depression		Cervical Spine Arthritis		Diabetes Mellitus
	Glaucoma		Macular Degeneration		Parkinson's Disease		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:

Symptom	Yes	No
Lightheadedness or a floating sensation?		
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?

√	Test/Therapy	When	Where	Results
	ENG/VNG			
	CT Scan or MRI			
	Hearing test			
	Rehabilitation (PT or OT)			Did it help? ☐ yes ☐ no

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. Hydrochlorothyazide ☐ 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.