



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
<input type="checkbox"/>	Rolling your body to the left	<input type="checkbox"/>	Rolling your body to the right
<input type="checkbox"/>	Moving from a lying to a sitting position	<input type="checkbox"/>	Looking up with your head back
<input type="checkbox"/>	Turning head side to side while sitting/standing	<input type="checkbox"/>	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
<input type="checkbox"/>	Moving my head	<input type="checkbox"/>	Physical activity or exercise
<input type="checkbox"/>	Riding or driving in the car	<input type="checkbox"/>	Large crowds or a busy environment
<input type="checkbox"/>	Loud sounds	<input type="checkbox"/>	Coughing, blowing the nose, or straining
<input type="checkbox"/>	Standing up	<input type="checkbox"/>	Eating certain foods
<input type="checkbox"/>	Time of day	<input type="checkbox"/>	Menstrual periods (if applicable)
<input type="checkbox"/>	Stress	<input type="checkbox"/>	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
<input type="checkbox"/>	Migraines	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Tumor	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	Neuropathy	<input type="checkbox"/>	Panic attacks/Anxiety	<input type="checkbox"/>	Congestive heart failure
<input type="checkbox"/>	Concussion	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Cervical Spine Arthritis	<input type="checkbox"/>	Diabetes Mellitus
<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	Parkinson's Disease	<input type="checkbox"/>	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? <input type="checkbox"/> yes <input type="checkbox"/> 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. 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.