

## Confidential Vestibular Patient Medical History

**Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Describe injury or events leading to onset of symptoms/dizziness: \_\_\_\_\_  
 \_\_\_\_\_

Please indicate your dizziness levels: Least: \_\_\_\_\_ Worst: \_\_\_\_\_

(0= dizziness/ 10= worst dizziness imaginable)

Describe you dizziness I.E., spinning, rolling, etc.) \_\_\_\_\_

What activities increase dizziness? \_\_\_\_\_

What activities decrease dizziness? \_\_\_\_\_

Are medications being taken for the condition  Yes  No

If yes, please list: \_\_\_\_\_

Have any of the following been performed for this condition?

ENG/ Posturography \_\_\_\_\_ Date: \_\_\_\_\_

X-rays Body Part: \_\_\_\_\_ Date: \_\_\_\_\_

MRI Body Part: \_\_\_\_\_ Date: \_\_\_\_\_

CT Scan Body Part: \_\_\_\_\_ Date: \_\_\_\_\_

Other: \_\_\_\_\_

Have you had trouble sleeping?  Yes  No

How often do you awaken at night due to symptoms? \_\_\_\_\_

Have you had, or do you currently have, problems with any of the following?

	Yes	No		Yes	No
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Previous Surgery	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Imbalance	<input type="checkbox"/>	<input type="checkbox"/>	Bowel/ Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Infections	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Metal Implants	<input type="checkbox"/>	<input type="checkbox"/>			

Pregnant

How many weeks \_\_\_\_\_ Months \_\_\_\_\_

Other: \_\_\_\_\_