Patient Name: _____ **Date of Birth:** _____

Provider Name: _____ **Appointment Date:** _____

Last 4 Digits Social Security # _____ **Sex:** Male

CURRENT SYMPTOMS

Are your symptoms: Dizziness

Which of the following bests describes your symptoms?

- ☐ Imbalance
- ☐ Falling more often
- ☐ World spinning around you
- ☐ You feel as if YOU are spinning; the room is not spinning
- ☐ Nausea
- ☐ Lightheadedness
- ☐ Other: _____

When did your symptoms begin? _____ (estimate if needed)

How long do your symptoms last without stopping?

- ☐ Seconds
- ☐ Minutes
- ☐ Hours
- ☐ Days
- ☐ Symptoms are constant

Did any of the following occur before your symptoms began?

- ☐ Head trauma
- ☐ Motor Vehicle Accident
- ☐ Upper Respiratory Infection
- ☐ Change in medication
- ☐ A virus or infection, e.g., Shingles, Cold Sores
- ☐ Surgery

- [ ] Stressful event or high stress
- [ ] A fall
- [ ] Other: _____

How many times per Year do you have an episode? _____

Which of the following can provoke, increase, or worsen your dizziness?

- [ ] Laying down
- [ ] Looking up
- [ ] Bending over
- [ ] Standing up from bending over
- [ ] Turning your head right or left while seated or standing
- [ ] Rolling over in bed
- [ ] Standing up from a seated position OR sitting up from a laid position
- [ ] Increased Stress
- [ ] Skipping a meal
- [ ] Not drinking enough water
- [ ] Other: _____

Have your symptoms Improved since they began?

If Improved or Changed: How so? _____

Does anything make your symptoms better? _____

Which of the following accompany or occur immediately prior to an episode of your symptoms?

- [ ] Headaches
- [ ] Neck Pain
- [ ] Hearing Loss: Right
- [ ] Fullness in your ear(s): Right
- [ ] Ringing in your ear(s): Right
- [ ] Shimmers or Sparkles in your Vision
- [ ] Sensitivity to Light, Sound, & Smell

BALANCE & FALL SYMPTOMS

Yes : Have you fallen in the past year?

If yes: How many times? _____
If no: Have you experienced "near falls" but you caught yourself? Yes

Yes : Are you afraid of falling?

Yes : Are you veering/leaning while walking? *If yes:* Which direction? Right

Yes : Do you have neuropathy, numbness, or tingling in your feet or legs?

Yes : Has your exercise decreased? *If yes:* Approximately when? _____

Yes : Orthopedic injuries? *If yes:* Please explain: _____

MEDICAL HISTORY

Yes : Do you have a history of Migraines?

If yes: When was your most recent Migraine? _____

Yes : Are you bothered by patterns, screens, or complex visual environments, e.g., supermarkets?

Yes : Are your Blood Sugar, Blood Pressure, and Thyroid Levels well controlled?

Yes : Have you had any recent changes in hearing?

If yes: Which ear? Right

If yes: When was your last hearing evaluation? _____

Yes : I am experiencing ear Ringing, Drainage & Fullness

If yes: Which ear? Right

Yes : Do you have any known eye/vision issues?

If yes: Please explain: _____

IF APPLICABLE: FEMALE HORMONAL HISTORY

Are you Pre Menopausal?

Yes : Do you currently get hot flashes?

Yes : Did you have a hysterectomy? *If yes:* When? _____

Yes : Have you had any changes to your contraceptives? *If yes:* When? _____

Yes : Do you have known hormonal imbalance?

If yes: Are you being treated for this issue? Yes

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