

Patient Name: \_\_\_\_\_

Date of Birth \_\_\_ / \_\_\_ / \_\_\_\_

Provider Name: \_\_\_\_\_

Appt Date: \_\_\_ / \_\_\_ / \_\_\_\_

Sex: Male / Female

**CURRENT SYMPTOMS**

Which of the following best describes your symptoms?

- Imbalance
- Falling more often
- World spinning around you
- You feel as if YOU are spinning; the world is not spinning
- Nausea
- Lightheadedness
- Other: \_\_\_\_\_

How long do your symptoms last **without** stopping?

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

How many times per **day / week / month / year** (*circle one*) do you have an episode? \_\_\_\_\_

Did any of the following occur prior to your symptom onset? (**check all that apply**)

- Head trauma
- Motor Vehicle Accident
- Upper Respiratory Infection
- Change in medication
- A Fall
- Other: \_\_\_\_\_
- A virus or infection, e.g., Shingles, Cold Sores, COVID-19
- Surgery
- Stressful event or high stress

**Circle One:** Have your symptoms Improved/Changed/Stayed the Same since they began?

*If Improved or Changed:* How so? \_\_\_\_\_

Does anything make your symptoms better? \_\_\_\_\_

**BALANCE & FALL SYMPTOMS (Circle Y for Yes, Circle N for No)**

**Y N** Have you fallen in the past year?

*If yes:* How many times? \_\_\_\_\_

*If no:* Have you experienced “near falls” but you caught yourself? **YES / NO**

**Y N** Are you afraid of falling?

**Y N** Are you veering/leaning while walking? *If yes:* Which direction? **Right, Left, Both**

**Y N** Do you have neuropathy, numbness, or tingling in your feet or legs?

**Y N** Has your exercise decreased? *If yes:* Approximately when? \_\_\_\_\_

**Y N** Orthopedic injuries? *If yes:* Please explain: \_\_\_\_\_

## **DIZZINESS SYMPTOMS**

**Y N** Do you have a history of Migraines? *If yes:* When was your most recent Migraine? \_\_\_\_\_

Do any of the following trigger your symptoms? **(check all that apply)**

- Increased stress
- Skipping a meal
- Not drinking enough water
- Changes in weather
- Certain foods: \_\_\_\_\_

Do any of the following **accompany** or occur **immediately prior** to an episode of your symptoms?

**(check all that apply)**

- Headaches
- Neck Pain
- Hearing Loss: **right ear, left ear, both ears** (*circle one*)
- Fullness in your ear(s): **right ear, left ear, both ears** (*circle one*)
- Ringing in your ear(s): **right ear, left ear, both ears** (*circle one*)
- Shimmers or Sparkles in your Vision
- Sensitivity to **light, sound, smell** (*circle all that apply*)

## **(Circle Y for Yes, Circle N for No)**

**Y N** My dizziness is intense but only lasts for seconds or minutes

**Y N** I get dizzy when I turn over in bed

**Y N** I get short-lasting, spinning dizziness that happens when I bend down to pick something up

**Y N** I get short-lasting, spinning dizziness that happens when I go from sitting to lying down

**Y N** I can trigger my dizzy spells when by placing my head in certain positions

**Y N** I have had a single severe spell of spinning dizziness that lasted for hours to a day

**Y N** After my big episode of dizziness, I could not walk for days without falling over

**Y N** I had a spell of spinning dizziness that lasted for hours after I had a cold, virus, or flu

**Y N** I had hearing loss in one ear at the same time I had the long episode of spinning dizziness

**Y N** I have spells where I get dizzy, and it is difficult for me to breathe

**Y N** I feel dizzy all of the time

**Y N** I am anxious most of the time

- Y N I am bothered by patterns, screens, e.g., supermarkets
- Y N My symptoms increase when I go from laying to sitting or sitting to standing
- Y N When I cough or sneeze, I get dizzy
- Y N I get dizzy when I strain to lift something heavy
- Y N When I speak, my voice sounds abnormally loud to me
- Y N My dizziness is provoked with head movements (up/down and/or right/left)
- Y N My head is heavy like a bowling ball
- Y N I have a headache that is in or starts in the back of my head
- Y N When I sit up from lying down, or stand up from sitting, I experience a few seconds of dizziness

### MEDICAL HISTORY

Y N Are your Blood Sugar, Blood Pressure, and Thyroid Levels well controlled?

Y N Do you have any known eye/vision issues?

*If yes:* Please explain: \_\_\_\_\_

Y N Do you have hearing loss?

*If yes:* Which ear? **right ear, left ear, both ears** (circle one)

*If yes:* Was it sudden? Y N

Y N Do you wear hearing aids?

Y N I am experiencing ear **Pain / Ringing / Drainage / Fullness** (circle all that apply)

*If yes:* Which ear? **right ear, left ear, both ears** (circle one)

### IF APPLICABLE: FEMALE HORMONAL HISTORY

**Circle One:** Are you **Pre/Peri/Post**-Menopausal?

Y N Did you have a hysterectomy? *If yes:* When? \_\_\_\_/\_\_\_\_/\_\_\_\_

Y N Have you had any changes to your contraceptives? *If yes:* When? \_\_\_\_/\_\_\_\_/\_\_\_\_

Y N Do you have known hormonal imbalance? *If yes:* Are you being treated for this issue? Y N