Audiology Associates of Redding

Vestibular History

Patient Name _____ Date _____ /_____ /_____
First Last MI mm dd yyyy

Address _____
Street City State Zip

Home Phone _____ Other Phone _____

Sex ☐ M ☐ F Birth Date _____ Email Address _____

Primary Care Physician _____ Referring Physician _____

The following questions refer to the dizziness that you are experiencing. Please answer the questions to the best of your ability.

1. In your own words, please describe the sensations you feel without using the word "dizzy":

2. Do you experience any of the following:
   - ☐ Yes Feeling as if the world is spinning around you? _____
   - ☐ Yes A spinning feeling inside your head? _____
   - ☐ Yes Falling/pulling to one side while walking? _____
   - ☐ Yes Imbalance while walking? _____

3. The following refer to a typical dizzy spell:
   - ☐ Yes Is your dizziness constant? _____
   - ☐ Yes Do the dizzy spells come in attacks? _____
     If so, how often? _____
     How long? _____
     Date of the first spell _____
   - ☐ Yes Are you free from dizziness between attacks? _____
   - ☐ Yes Does your hearing change with an attack? _____
   - ☐ Yes Do you experience a fullness or pressure in your ears during an attack? _____
   - ☐ Yes Are you more dizzy in certain positions? _____
     If so, which positions? _____
   - ☐ Yes Are you nauseated during an attack? _____
   - ☐ Yes Are you dizzy when lying down? _____
   - ☐ Yes Have you had a recent cold or flu preceding your dizziness? _____
   - ☐ Yes Do you have trouble walking in the dark? _____
   - ☐ Yes Are you better if you sit or lie perfectly still? _____

4. The following refer to other sensations you may have:
   - ☐ Yes Do you have lightheadedness or a "swimming sensation" while dizzy? _____
   - ☐ Yes Have you blacked out or fainted while dizzy? _____
   - ☐ Yes Do you have severe or recurrent headaches? _____
   - ☐ Yes Do you have migraine headaches? _____
   - ☐ Yes Do you experience blurred or double vision? _____
   - ☐ Yes Do you experience numbness / tingling in your face or extremities? _____

☐ Yes Have you experienced weakness or clumsiness in your arms, legs? _____
☐ Yes Have you ever experienced slurred speech? _____
☐ Yes Have you had trouble swallowing? _____
☐ Yes Have you experienced spots / floaters in your visual field? _____
☐ Yes Have you ever noticed jerking or your arms or legs? _____
☐ Yes Have you had a head injury with loss of consciousness? _____
☐ Yes Do you experience confusion or memory loss? _____
☐ Yes Are you sensitive to motion / movement? _____
☐ Yes Do you experience sensitivity to bright light? _____
☐ Yes Do you experience sensitivity to loud sounds? _____
☐ Yes Do you experience sensitivity to strong smells? _____

5. Is your dizziness related to:
☐ Yes Increased stress in your life? _____
☐ Yes Your menstrual period? _____
☐ Yes Physical exertion? _____
☐ Yes A recent change in eyeglass prescription? _____

6. The following refer to your hearing:
☐ Yes Do you have a loss of hearing?
If so, which ear(s) _____

☐ Yes Do you experience ringing in your ears?
If so, which ear(s) _____

☐ Yes Do you have fullness or pressure in your ear(s)?
If so, which ear(s) _____

☐ Yes Do you have pain in your ear(s)?
If so, which ear(s) _____

☐ Yes Do you have a history of loud noise exposure? _____
☐ Yes Do you have a history of ear infections? _____
☐ Yes Is there a family history of hearing loss? _____

7. The following refer to lifestyle and habits:
☐ Yes Do you drink coffee or tea?
How much? _____

☐ Yes Do you drink soft drinks?
How much? _____

☐ Yes Do you drink alcohol?
How much? _____

☐ Yes Do you smoke?
What? _____ How much? _____

8. Medical history. Please list your current medical problems and length of illness:

9. Medications. Please list all medications, both non-prescription and prescription, you currently take, as well as dosage and frequency:

10. What studies/evaluations have you had previously to assess for this problem (ie. MRI, MRA, CT scan, EKG, neurology evaluation, etc)? Please include your results/impressions:

Additional comments or concerns: