**A close-up of a sign

Description automatically generated**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

**Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Appointment Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

**Last 4 Digits Social Security # \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ Sex: Male / Female**

**CURRENT SYMPTOMS**

**Circle One:** Are your symptoms **Dizziness / Imbalance/ Both**

Which of the following best 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 day**/ week/ month/ year/** (circle one) do you have an episode? \_\_\_\_\_\_\_

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

Lying 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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)

**BALANCE & FALL SYMPTOMS**

**YES/NO:** Have you fallen in the past year?

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

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

**YES/NO:** Are you afraid of falling?

**YES/NO:** Are you veering/ leaning while walking? *If yes:* Which direction? **Right, Left, Both**

**YES/NO:** Do you have neuropathy, numbness, or tingling in your feet or legs?

**YES/NO:** Has your exercise decreased? *If yes:* Approximately when? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**YES/NO:** Orthopedic injuries? *If yes:* Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

**YES/NO:** Do you have a history of Migraines?

*If yes:* When was your most recent Migraine? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**YES/NO:** Are you bothered by patterns, screens, or complex visual environments, e.g., supermarkets?

**YES/NO:** Are your Blood Sugar, Blood Pressure, and Thyroid Levels well controlled?

**YES/NO:** Have you had any recent changes in hearing?

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

*If yes:* When was your last hearing evaluation? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**YES/NO:** I am experiencing **Pain/** **Ringing/** **Drainage/** **Fullness** (circle all that apply).

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

**YES/NO:** Do you have any known eye/vision issues?

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

**IF APPLICABLE: FEMALE HORMONAL HISTORY**

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

**YES/NO:** Do you currently get got flashes?

**YES/NO:** Did you have a hysterectomy? *If yes:* When? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**YES/NO:** Have you had any changes to your contraceptives? *If yes:* When? \_\_\_\_/\_\_\_\_\_/\_\_\_\_

**YES/NO:** Do you have a known hormonal imbalance? *If yes:* Are you being treated for this issue? **YES/NO**