*Excellence in Specialty Care for the Head and Neck ~ A Division of Select Physicians Alliance, PL*

# INITIAL EVALUATION
# BALANCE/VESTIBULAR HISTORY QUESTIONNAIRE

NAME:____________________________________________DATE:______________________
REFERRING PHYSICIAN:______________________________GLASSES:___________________
DATE OF BIRTH:____________________________HEARING AID:_______________________
CHIEF COMPLAINT:_____________________________________________________________
OCCUPATION:_________________________________________________________________

**DIZZY/VERTIGO HISTORY:**

1. When was your first dizzy/vertigo attack (give approximate date/year__________________
2. How long did the attack last (seconds, minutes, days)________________________________
3. Was your dizziness constant or intermittent?______________________________________
4. Did you feel better lying perfectly still? Yes or no__________________________________
5. Was the environment spinning? Yes or no_________________________________________
6. Were you spinning? Yes or no___________________________________________________
7. Did you feel like you were pulled to one side? Yes or no______________________________
8. Did you feel like you were pulled to forward? Yes or no_______________________________
9. Did you feel like you were pulled backward? Yes or no________________________________
10. Did you feel like you were rising upward? Yes or no________________________________
11. Did you feel like you were sinking to the ground? Yes or no__________________________
12. Did your world seem distorted in any way? Yes or no_______________________________
13. Have you had additional attacks since the first one? How many?______________________
14. Are you fatigued before or after the attack? Before, after or both?____________________
15. Does stress bring the attacks on? Yes or no________________________________________
16. Do you have **hearing loss, ringing or fullness** in the ears? Yes or no__________________
    Which problem and which ear?__________________________________________________
17. Do you notice blurred vision with **head movement or walking**? ______________________
18. Does a certain movement provoke the attack? (i.e., lying on back, rolling over in bed, making the bed, looking up/bending over, describe the movement._______________________
___________________________________________________________________________________
19. Are attacks aggravated during menstruation? Yes or no______________________________
20. Were you ever dizzy or have vertigo as a child, have difficulty riding in a car, plane or boat? Yes or no, which one provoked you?___________________________________________
21. Do you have nausea or vomiting with attacks? Yes or no_____________________________
22. Could you have an attack without any movement associated with it? Yes or no_________
23. Can any of the following provoke the attack: (check one)

| | | |
|---|---|---|
| riding in a car_______ | driving in a car______ | riding in an elevator_______, |
| going up stairs______ | going downstairs____ | shopping in grocery store_______, |
| walking in the dark____ | reaching up________ | walking on thick grass/gravel_____ |
| watching TV________ | loud noises_____ | people moving around you_______, |
| bright lights_________ | reading__________. | |

24. Have you seen a vestibular physical therapist for this problem before?_______________

**FALL HISTORY**

25. When did you fall?______________________________
26. How often do you fall?______________________________
27. Was there an injury when you fell?______________________________

**MEDICAL HISTORY**

28. Have you had surgery? List dates/types______________________________
29. List drug therapy, (chemo/antibiotic, etc)______________________________
30. List heart problems, mitral valve prolapse, hypertension, palpations, irregular beats, etc.
______________________________

**Please check all that apply**

| | | |
|---|---|---|
| _______Lung problems | _______Thyroid problems | _______Allergies |
| _______Accidents | _______Head injury/whiplash | _______ Fainting or blackouts |
| _______Meniere's Disease | _______Vitamin B-12 deficiency | _______Other anemia |
| _______Asthma | _______Infections? (Ear, other) | _______ Weight loss |
| _______ Stress | _______ Diabetes | _______ Convulsions/seizures |

_______Severe or recurrent headaches
_______Pain or numbness in face, arms, legs
_______Twitching or weakness of face, arms, legs
_______ Ringing in ears, steady or pulsating
_______TMJ? (Pain, grinding in back of jaw)
_______ Trouble chewing, swallowing or speaking
_______Psychiatric disorders

**DIET HISTORY**

Do you notice an association with these foods and increased dizziness?
(Circle one) salt, fat, fluid intake, MSG, tea, coffee, other sweets, alcohol, tobacco.

**CRITICAL BEHAVIOR/COGNITIVE STATUS**

Has your concentration, memory or alertness been affected by the dizziness/vertigo attacks?______________________________

Do you feel your spouse is supportive in relation to your dizzy/vertigo attacks?__________
______________________________

Do you feel your friends are supportive in relation to your dizzy/vertigo attacks?_________
______________________________

What social or household activities have you stopped in relation to your dizzy/vertigo attacks? (please circle) grocery shopping, driving, seeing family/friends, dancing, sports, walking, house chores, going to church, etc.

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**STUDIES (List dates and results)**

Glucose tolerance test________________________________________________
Thyroid test__________________________________________________________
Vitamin B-12 test_____________________________________________________
CT scan of head/neck__________________________________________________
MRI of head/neck_____________________________________________________
X-rays______________________________________________________________
Arteriogram__________________________________________________________
Sinus X-rays_________________________________________________________
Holter monitor________________________________________________________
ENG________________________________________________________________
Audiogram___________________________________________________________
Mammogram__________________________________________________________
GYN exam (pelvic exam)_________________________________________________

COMMENTS BY PHYSICIAN:

______________________________________________________________________________
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**REVIEWED BY:** **SANFORD DOLGIN, MD**______________________________

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