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

Provider Name: _____ **Appt Date:**

Sex:

CURRENT SYMPTOMS

Which of the following bests 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 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

Choose One: Have your symptoms Stayed the Same since they began?

If Improved or Changed: How so?

Does anything make your symptoms better?

BALANCE & FALL SYMPTOMS (Choose Yes or No)

No Have you fallen in the past year?

If yes: How many times? _____

If no: Have you experienced "near falls" but you caught yourself? No

No Are you afraid of falling?

No Are you veering/leaning while walking? *If yes:* Which direction? Left

No Do you have neuropathy, numbness, or tingling in your feet or legs?

No Has your exercise decreased? *If yes:* Approximately when? _____

No Orthopedic injuries? *If yes:* Please explain: _____

DIZZINESS SYMPTOMS

No 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 Both
- ☐ Fullness in your ear(s) Both
- ☐ Ringing in your ear(s) Both
- ☐ Shimmers or Sparkles in your Vision
- ☐ Sensitivity to Light
  Sound
  Smell

(Choose Yes or No)

No My dizziness is intense but only lasts for seconds or minutes

No I get dizzy when I turn over in bed

No I get short-lasting, spinning dizziness that happens when I bend down to pick something up

No I get short-lasting, spinning dizziness that happens when I go from sitting to lying down

No I can trigger my dizzy spells when by placing my head in certain positions

No I have had a single severe spell of spinning dizziness that lasted for hours to a day

No After my big episode of dizziness, I could not walk for days without falling over

No I had a spell of spinning dizziness that lasted for hours after I had a cold, virus, or flu

No I had hearing loss in one ear at the same time I had the long episode of spinning dizziness

No I have spells where I get dizzy, and it is difficult for me to breathe

No I feel dizzy all of the time

No I am anxious most of the time

No I am bothered by patterns, screens, e.g., supermarkets

No My symptoms increase when I go from laying to sitting or sitting to standing

No When I cough or sneeze, I get dizzy

No I get dizzy when I strain to lift something heavy

No When I speak, my voice sounds abnormally loud to me

No My dizziness is provoked with head movements (up/down and/or right/left)

No My head is heavy like a bowling ball

No I have a headache that is in or starts in the back of my head

No When I sit up from lying down, or stand up from sitting, I experience a few seconds of dizziness

MEDICAL HISTORY

No Are your Blood Sugar, Blood Pressure, and Thyroid Levels well controlled?

No Do you have any known eye/vision issues?

If yes: Please explain:

No Do you have hearing loss?

If yes: Which ear? Both

If yes: Was it sudden? No

No Do you wear hearing aids?

No I am experiencing ear Pain Ringing Drainage Fullness

If yes: Which ear? Both

IF APPLICABLE: FEMALE HORMONAL HISTORY

Are you Post -Menopausal?

No Did you have a hysterectomy? *If yes:* When?

No Have you had any changes to your contraceptives? *If yes:* When?

No Do you have known hormonal imbalance? *If yes:* Are you being treated for this issue? No

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