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

Provider Name: _____ **Appt Date:** ___ / ___ / _____

Sex: Male / Female

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 / 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**