Coastal Carolina Otolaryngology

COA

Vestibular Medical History Questionnaire

Name: ______________________________ Date of Birth: ______________

Today's Date: ____________ ENT/Physician Referred: ______________________________

Initial Onset

Describe what happened the first time you experienced dizzy/imbalance symptoms:

Symptoms

Please check all that apply.

- ☐ Dizziness
- ☐ Visual changes
- ☐ Falling
- ☐ Hearing loss
- ☐ Fatigue
- ☐ Nausea/Vomiting
- ☐ Spinning
- ☐ Double vision
- ☐ Lightheadedness
- ☐ Headache
- ☐ Brain fog
- ☐ Noise in ears
- ☐ Fullness, pressure or pain in ears
- ☐ Unsteadiness
- ☐ Rocking/Tilting
- ☐ Fainting

History of Present Illness

Describe your current problem:

When did your problem start (date)? ______________________________

Was it associated with a related event (e.g., head injury)? ☐ Yes ☐ No

If yes, please explain: ______________________________

____

____

Was the onset of your symptoms ☐ Sudden ☐ Gradual ☐ Overnight ☐ Other

Please describe: ______________________________

Are your symptoms ☐ Constant ☐ Variable (i.e., come and go in spells)

If variable:

The spell occurs every number of: ________ Hours ________ Days ________ Weeks

________ Months ________ Years

The spell lasts ☐ Seconds ☐ Minutes ☐ Hours ☐ Days

Do you have any warning signs that a spell is about to happen? ☐ Yes ☐ No

If yes, please describe: ____

____

Are you completely free of symptoms between spells? ☐ Yes ☐ No

Do your symptoms occur when changing positions? ☐ Yes ☐ No

If yes, check all that apply:

☐ Rolling your body to the left
☐ Rolling your body to the right
☐ Moving from a lying to sitting position
☐ Looking up with your head back
☐ Turning head side to side while sitting/standing
☐ Bending over with your head down

Is there anything that makes your symptoms better? ☐ Yes ☐ No

If yes, please explain: ____

Is there anything that makes your symptoms worse? ☐ Yes ☐ No

If yes, check all that apply:

☐ Moving your head
☐ Riding/Driving in a car
☐ Loud sounds
☐ Standing up
☐ Time of day
☐ Physical activity or exercise
☐ Large crowds or busy environments
☐ Coughing, blowing nose
☐ Eating certain foods
☐ Stress

When you have symptoms, do you need to support yourself to stand or walk? ☐ Yes ☐ No

If yes, how do you support yourself? ____

Have you ever fallen as a result of your current problem? ☐ Yes ☐ No

Do you have a history of any of the following? Check all that apply.

☐ Migraines
☐ Multiple sclerosis
☐ Panic attacks/Anxiety
☐ Glaucoma
☐ Seizures
☐ Neuropathy
☐ Depression
☐ Macular degeneration
☐ Tumor
☐ Congestive heart failure
☐ Cervical spine arthritis
☐ Parkinson’s disease
☐ Stroke
☐ Concussion
☐ Diabetes mellitus
☐ Ataxia

Has there been a recent change in your vision, including contacts or glasses? ☐ Yes ☐ No

Describe any ear-related symptoms.

Do you have any difficulty with hearing? ☐ Yes ☐ No

If yes, which ear(s)? ☐ Left ☐ Right ☐ Both

When did this start? ____

Do your ear symptoms occur at the same time as your dizziness/imbalance symptoms? ☐ Yes ☐ No

When you are walking, do you: ☐ Veer left? ☐ Veer right? ☐ Remain on a straight path?

<u>Habits</u>

Please describe your habits in regard to the following substances:

Caffeine
☐ I do not consume caffeine.
☐ I consume caffeine.

I drink __________ cups of ___________________ (e.g., coffee) per ___________________________ (time period).

Tobacco

☐ I do not consume tobacco.

☐ I consume tobacco.

I smoke/chew ________ (amount) of _________________ (product) per _________________________ (time period).

Alcohol

☐ I do not consume alcohol.

☐ I consume alcohol.

I drink ________ glasses of _________________ (e.g., wine) per ______________________________ (time period).

Recreational drug use

☐ I do not use drugs.

☐ I use ____.

How many times per day? ________ For how many years? ____

Medications

☐ I do not take any medications.

☐ I take the following medications.

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