Shull Physical Therapy Center
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Vestibular Rehabilitation
Dizziness & Balance Medical History Questionnaire

Please answer the following questionnaire to assist the physical therapist treating your case. If there are any questions, please ask the receptionist. Thank you for your cooperation during this investigative process.

Today's Date:_____

Name:_____ Date of Birth:_____

I. Initial Onset

Describe what happened the first time you experienced dizzy/imbalanced symptoms.

II. Symptoms

In the box after each symptom, rate the severity of that symptom using a scale of **0-10**, with 10 being most severe.

Symptom	1-10	Symptom	1-10	Symptom	1-10	Symptom	1-10
Dizziness		Spinning		Lightheadedness		Rocking/Tilting	
Visual Changes		Headache		Fatigue		Unsteadiness	
Falling		Noise in ears		Brain fog		Fainting	
Hearing Loss		Double Vision		Fullness, pressure, or pain in ear		Other:	

III. History of Present Illness

- Problem start date:_____
- Was the problem associated with a related event (i.e. head injury)? ◯ **Yes** ◯ **No**
  If yes, please explain:_____
- Was the onset of your symptoms: ◯ **sudden** ◯ **gradual** ◯ **overnight** ◯ **other**
  Describe:_____
- Are your symptoms: ◯ **constant** ◯ **variable** (i.e. come and go in spells)
  If variable:
  The spells occur every # of: _____hours _____ days _____weeks _____months _____ years

  Do you have any warning signs when a spell is about to happen?
  _____
  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

- When symptoms occur, do you need to support yourself to stand or walk?
  ◯ **Yes** ◯ **No** How do you support yourself?_____
- When walking, do you: ◯ **veer left?** ◯ **veer right?** ◯ **remain straight?**
- Have you ever fallen as a result of your current problem? ◯ **Yes** ◯ **No**
- Do you have a history of any of the following?
  If yes, check all that apply:

	Migraines		Seizures		Macular Degeneration		Stroke
	Multiple Sclerosis		Neuropathy		Panic attacks/Anxiety		Concussion
	Cervical spine arthritis		Glaucoma		Congestive heart failure		Ataxia
	Parkinson's disease		Tumors		Diabetes Miletus		Depression

- Do you have difficulty hearing? ◯ **Right Ear** ◯ **Left Ear** ◯ **No**
  When did this start? _____
- Do your ear symptoms occur at the same time as your dizziness/imbalance symptoms? ◯ **Yes** ◯ **No**

IV. Prior relevant medical evaluations, diagnostic testing, and treatment:

- Have you seen other healthcare providers for your condition? ◯ **Yes** ◯ **No**
  If yes, who? ◯ **Primary care doctor** ◯ **ENT/HNS doctor** ◯ **Neurologist**
  ◯ **Cardiologist** ◯ **Emergency Room doctor** ◯ **Physical therapist**
- Have you had any of the following done for this condition elsewhere?

Test/Therapy	**When**	**Where**	**Results**
ENG/VNG			
CT Scan or MRI			
Rehabilitation (PT or OT)			Did it help? ◯ Yes ◯ No

- Are you currently taking any medications?
  ◯ Meclizine
  ◯ Ativan
  ◯ Hydrochlorothiazide
  Other medications:
  _____

Prior Surgical History

Surgery	**Year**

V. Additional Information

Is there any additional information you would like the therapist to know?