ADVANTAGE
Therapy Centers
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Tel (856) 424-2000 Fax (856) 424-2007

Vestibular History

Date: _____

Patient Name: _____SSN: _____

Occupation (current or former): _____Age: _____

Primary Care Physician: _____Referring Physician: _____

Dizziness and Balance History

Do you experience chronic dizziness? ☐ Yes ☐ No

When did this problem start?_____

How often do the symptoms occur?_____

How long do the symptoms last?_____

Do any of the following accompany your dizziness:

- ☐ Vertigo (sensation that you or the room is spinning)
- ☐ A change in vision (double-vision, blurred vision, etc)
- ☐ Headaches
- ☐ Nausea
- ☐ Ear pain
- ☐ Ringing or other noises in ear
- ☐ Numbness or weakness in face, arms, or legs

How often do you experience dizziness?_____

Do the symptoms occur or worsen at particular times? ☐ Yes ☐ No

If yes, when or under what circumstances?_____

Do the symptoms improve at any particular times? ☐ Yes ☐ No

If yes, when or under what circumstances?_____

Are there any other words that best describe your symptoms?_____

Do you ever experience unsteadiness or a fear of falling when you are not dizzy? ☐ Yes ☐ No

If yes, please describe_____

Medical History

Are you currently taking any prescription or nonprescription medications? ☐ Yes ☐ No

Please list each: _____

For what condition? _____

Are you currently being treated for high or low blood pressure? ☐ Yes ☐ No

Describe: _____

Have you ever had an illness with a high fever? ☐ Yes ☐ No

Describe the illness:_____

Are you currently being seen by a physician for ear problems? ☐ Yes ☐ No

If yes, what is the reason? _____ Physician?_____

Have you ever had ear surgery? ☐ Yes ☐ No Describe:_____

Have you ever experienced any of the following symptoms in one or both ears? ☐ Drainage ☐ Pain

Have you ever experienced **chronic:** ☐ Dizziness ☐ Nausea ☐ Headaches ☐ Allergies

Describe:_____

Have you ever experienced head or neck trauma? ☐ Yes ☐ No

Describe:_____

Have you ever been knocked unconscious? ☐ Yes ☐ No

Have you seen a physician in the last year? ☐ Yes ☐ No

For what reasons:_____

Have you been treated for any medical conditions not listed above? ☐ Yes ☐ No

Describe conditions and when occurred:_____

_____

_____

Do you have any vision problems, including corrected vision? ☐ Yes ☐ No

Describe or list degree of correction:_____