ADVANTAGE
Therapy Centers
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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 symptoms occur? _____

How long do the symptoms last? _____

Do any of the following accompany your dizziness:

- ❑ Vertigo (sensation that you are 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: _____