Family Audiology ASSOCIATES
www.FamilyAudiology.com AudigyCertified™

CELINA
Community Medical Center
950 S Main St, Ste 4
419.584.2255

ST. MARYS
Joint Township District Memorial Hospital
200 St. Clair St
419.394.3335

Vestibular Patient Questionnaire

Name _____ Date_____

Does your medical history include:

YES	NO	
☐	☐	Headaches – chronic or migraine
☐	☐	Fatigue
☐	☐	Difficulty hearing
☐	☐	Wearing eyeglasses or contacts
☐	☐	Sinus problems
☐	☐	Allergies

If yes, please list:

_____

_____

☐	☐	Back pain
☐	☐	Neck pain or whiplash
☐	☐	Head injury
☐	☐	Heart attack
☐	☐	Stroke
☐	☐	Vascular disease
☐	☐	Heart disease
☐	☐	High or low blood pressure
☐	☐	Respiratory problems
☐	☐	Diabetes
☐	☐	Surgery

If yes, please list the type of surgery and the date.

_____

_____

☐ ☐ Have you ever been diagnosed with a brain tumor, cancer, or neurological disorder/disease. What was the diagnosis?

_____

Who was the physician who diagnosed you?_____

When were you diagnosed?_____

☐ ☐ Currently taking medication. If yes, please list with dosage and frequency of use. Include vitamins, herbals, and over-the-counter medications. Use the back of this page

Have you ever experienced any of the following?

YES	NO	
☐	☐	Ringing in your ears
☐	☐	Fullness in your ears
☐	☐	Pain in your ears
☐	☐	Drainage from your ears

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YES	NO	
☐	☐	Double vision
☐	☐	Blurred vision or blindness
☐	☐	Problems with tears
☐	☐	Weakness in arms or legs
☐	☐	Feeling of pressure in your head
☐	☐	Numbness or tingling in face or extremities
☐	☐	Confusion or loss of consciousness
☐	☐	Difficulty swallowing
☐	☐	Problems with taste

Please read entire list first, and then check yes or no if you experience:

YES	NO	
☐	☐	Blackouts
☐	☐	Lightheadedness or floating sensation
☐	☐	Feel like you are spinning
☐	☐	Feel like the room is spinning
☐	☐	Loss of balance when walking and veer to the left
☐	☐	Loss of balance when walking and veer to the right
☐	☐	Tendency to fall to the left
☐	☐	Tendency to fall to the right
☐	☐	Tendency to fall backward
☐	☐	Tendency to fall forward
☐	☐	Difficulty walking in the dark
☐	☐	Constant dizziness
		When did the dizziness first occur?_____
☐	☐	Dizziness occurring in episodes or attacks
		If yes, how often?_____
☐	☐	Do you have any warning that the attack is about to start?
☐	☐	The dizziness only occurs in certain positions
		If yes, please explain_____
☐	☐	Do you know of anything that will stop your dizziness or make it better?
		If yes, please explain_____
☐	☐	Do you know of anything that will make your dizziness worse?
		If yes, please explain_____
☐	☐	Do you know of anything that will start the dizziness?
		If yes, please explain_____
☐	☐	In the last 12 months have you fallen to floor/ground? How many times?_____
☐	☐	Did any fall require you to get medical attention? If yes, please explain _____
		_____

Please check yes or no.

YES	NO	
☐	☐	Do you know or suspect what may have caused your dizziness?
		If yes, please explain_____
☐	☐	Were you ever exposed to any irritating fumes, paints, etc., prior to the onset of dizziness?
		If yes, please explain_____
☐	☐	Do you smoke or consume alcohol or caffeine?
		Circle one or all that apply Smoke Alcohol Caffeine
☐	☐	Did you get new glasses or contacts recently?

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Medication Form

Name _____

Allergies _____

_____

_____

_____

_____

Do you take a blood thinner? Yes_____ No_____

Include all prescriptions and over-the-counter medications (examples: aspirin, antacids) and herbals (examples: ginseng, gingko). Include medications taken as needed (example: nitroglycerin).

Date	Name of Medication/Dose	Directions/Notes	Date Stopped

Use another sheet of paper, if needed.