Patient Case History – Vestibular

THE Hearing & Dizziness CLINIC

AMHERSTBURG AUDIOLOGY & HEARING AIDS

Patient Name: _____ Date: _____

By signing I confirm that I have read your privacy policy and consent to treatment today **Signature:**_____

Please answer all of the following questions by circling the appropriate responses or by filling in the relevant blanks.

CHARACTERIZE YOUR DIZZINESS:

YES NO 1. Light-headedness, faintness, giddiness
YES NO 2. Unsteadiness, imbalance
YES NO 3. Objects are spinning around &you are still
YES NO 4. You are spinning around & objects are still
YES NO 5. Blackout or loss of consciousness
YES NO 6. Tendency to fall. Please circle the direction(s):

RIGHT FORWARD
LEFT BACKWARD

YES NO 7. Loss of balance when walking. If you ever veer or feel pulled to one side, please circle the direction(s):

TO THE RIGHT TO THE LEFT

ONSET AND COURSE:

YES NO 8. My dizziness is constant
YES NO 9. My dizziness comes in attacks/episodes
YES NO 10. My dizziness comes on suddenly
YES NO 11. I have no dizziness or imbalance between episodes
YES NO 12. I can tell when an episode is about to start.

How? _____
_____

13. Date of first dizzy episode: _____
Date of most recent dizzy episode: _____

14. On average, how long does your dizziness last?

Seconds Minutes Hours Days

15. On average, how often does your dizziness happen? Hourly Daily Weekly Monthly Seasonally Other

EXACERBATING AND REMITTING FACTORS:

YES NO 16. Turning my head makes dizziness start or worsen. Turning which direction? _____
YES NO 17. Lying down or sitting up brings on my dizziness
YES NO 18. Standing up brings on my dizziness
YES NO 19. Walking in the dark is especially difficult
YES NO 20. There is a relationship between my dizziness and stress or anxiety in my life.

Explain:_____
_____

21. Is there anything that will cause an episode?
_____
22. Does anything make your dizziness feel better?
_____

ASSOCIATED SYMPTOMS

YES NO23. Nausea or vomiting?
YES NO 24. Sweating?
YES NO 25. Deafness or difficulty hearing?
YES NO 26. Noises in ear (buzzing, ringing, roaring)
YES NO 27. Change in the noise when dizzy?
YES NO 28. Fullness or pain in ears?
YES NO 29. Drainage from ears?
YES NO 30. Headache or pressure in head with dizziness?
DURING AFTER
Where? _____
YES NO 31. Double vision, blurred vision, blindness?
YES NO 32. Weakness or clumsiness in arms/legs?
YES NO 33. Difficulty with speech or swallowing
YES NO 34. Neck or back pain?
YES NO 35. Depression or anxiety?
YES NO 36. I am able to go on with my usual activities while dizzy

PRESENT/PAST MEDICAL HISTORY

YES NO37. Head injury, concussion, skull fracture, knocked unconscious?
YES NO 38. Whiplash or neck disease?
YES NO 39. Eye disorder or eye surgery?
YES NO 40. Ear infections or other ear disease?
YES NO 41. Taking prescription or non-prescription drugs regularly before your dizziness started?
YES NO 42. Chemotherapy?
YES NO 43. Migraine?
YES NO 44. Drink alcohol? per day_____ years_____
45. Exposure to ototoxins? Check all that apply
□Caffeine □ Aspirin □ Quinine □ Tobacco □ Ethanol
□ Industrial Fumes □Intravenous Antibiotics (gentamicin/tobramycin)
46. Is there anything else that the audiologist should know?