

## Dizzy Medical History

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Please complete this form to the best of your ability. If you have any questions, please ask the receptionist.

Have you ever experienced any of the following (mark in column Y for yes, N for no):

	Y	N		Y	N		Y	N
Bladder Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis/Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>
Bowel Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Migraine	<input type="checkbox"/>	<input type="checkbox"/>	Recent Fever	<input type="checkbox"/>	<input type="checkbox"/>
Depression/Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Smoker	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Obesity	<input type="checkbox"/>	<input type="checkbox"/>	Taking Steroids	<input type="checkbox"/>	<input type="checkbox"/>
<b>Sinus Issues</b>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Joint Surgeries	<input type="checkbox"/>	<input type="checkbox"/>
Fullness in Ears	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>			
Noise in Ears	<input type="checkbox"/>	<input type="checkbox"/>	Circulatory Disorder	<input type="checkbox"/>	<input type="checkbox"/>			
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<i>Circle:</i> Upper / Lower Extremities					
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<i>List:</i> _____					
Eye health/surgeries _____								

*circle any that apply:*    glaucoma    macular degeneration    cataracts

Past medical history: \_\_\_\_\_

Previous dizziness episodes \_\_\_\_\_

Previous therapy \_\_\_\_\_

**Diagnostic tests:**    ENG    Computerized Posturography    Hearing    VEMP

**MRI:** Date: \_\_\_\_\_ Location: \_\_\_\_\_

Current medications: \_\_\_\_\_

Rate your Dizziness on a scale of 0 to 10 (0 if no symptoms, 10 is enough to severely interfere with function)

**at rest**                      0 \_\_\_\_\_ 10

**with activity**                0 \_\_\_\_\_ 10

Rate your Disequilibrium while:

**Standing**                    0 \_\_\_\_\_ 10

**Walking**                    0 \_\_\_\_\_ 10

