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DIZZINESS

Today's Date

Last Name First MI

Date of Birth Age

GENERAL PATIENT INFORMATION

You must complete or already have on file the ***patient medical history short form*** or ***long form***.
Please make sure that all of the information on your medical history form is updated including phone numbers, addresses and insurance information.
Answer the following questions and bring the answers to your appointment.

PRESENT ILLNESS – DIZZINESS

Which of these best describes your dizziness? Check only one.

- ☐ A sensation of movement of yourself or the room (spinning, tilting or wave-like movement)
- ☐ Lightheadedness or feeling that you are going to faint
- ☐ Loss of balance
- ☐ Disassociation or disorientation with the world

When you are dizzy, what sensations do you experience?

- ☐ Lightheadedness or swimming sensation in the head
- ☐ Blacking out or loss of consciousness
- ☐ Tendency to fall
- ☐ Objects spinning or turning around you
- ☐ Sensation that you are turning or spinning inside
- ☐ Loss of balance when walking
- ☐ Headache
- ☐ Pressure in the head
- ☐ Nausea or vomiting

When did the dizziness first occur:

Is the dizziness ☐ CONSTANT or does it come in ☐ ATTACKS?

If your dizziness comes in attacks, how often do they occur?

If your dizziness comes in attacks, how long do they last?

What factors provoke or worsen the dizziness?

What factors make the dizziness better?

Does your hearing change when the dizziness occurs?

☐ Yes ☐ No If YES, which ear is affected? ☐ Right ☐ Left ☐ Both

How does your hearing change?

Do you have any other symptoms associated with your dizziness?

☐ Visual changes ☐ Numbness or tingling in the arms or legs

☐ Changes in speech ☐ Weakness in the arms or legs

Are you completely free of dizziness between attacks? ☐ Yes ☐ No

Have you ever been diagnosed with a head or neck injury? ☐ Yes ☐ No

Do you have any history of a neurological disease such as migraine, multiple sclerosis or stroke?

☐ Yes ☐ No If YES, explain

Do you have any of the following hearing related symptoms?

Difficulty in hearing	☐ Yes	☐ No	☐ Right	☐ Left	☐ Both ears
Noise in your ears	☐ Yes	☐ No	☐ Right	☐ Left	☐ Both ears
Noise that changes during dizziness	☐ Yes	☐ No	☐ Right	☐ Left	☐ Both ears
Fullness or stuffiness in your ears	☐ Yes	☐ No	☐ Right	☐ Left	☐ Both ears

Have you experienced any of the following symptoms?

Double vision, blurred vision or blindness	☐ Yes	☐ No
Numbness of the face	☐ Yes	☐ No
Numbness of the arms or legs	☐ Yes	☐ No
Clumsiness of arms or legs	☐ Yes	☐ No
Confusion or loss of consciousness	☐ Yes	☐ No
Difficulty with speech	☐ Yes	☐ No
Difficulty with swallowing	☐ Yes	☐ No
Pain in the neck or shoulder	☐ Yes	☐ No

MEDICATIONS

What are your current medications, include hormones, birth control pills, vitamins, etc. (Name and amount/day)?

Medication	Amount	Medication	Amount
1		6	
2		7	
3		8	
4		9	
5		10	

Are you taking oral contraceptive pills? ☐ Yes ☐ No If YES, how long

Do you take any herbal supplements? ☐ Yes ☐ No

PAST MEDICAL HISTORY, REVIEW OF SYSTEMS

Check health issues you currently have or have had in the past:

General Health Problems

- ☐ Heart problems
- ☐ High cholesterol
- ☐ High or low blood pressure
- ☐ Diabetes
- ☐ Palpitations (abnormal or fast beating of the heart)
- ☐ Pain in back of jaw (TMJ)
- ☐ Migraine or other headaches
- ☐ Other pain, location or type:

Psychological Problems

- ☐ Treatment by a psychiatrist or counselor
- ☐ Depression or unusual amounts of stress
- ☐ Panic Attacks

Cancer

- ☐ What type:
- ☐ 15 lb or more weight loss

Systemic Diseases

- ☐ AIDS

Metabolic Problems

- ☐ Arthritis
- ☐ Blood diseases, anemia
- ☐ Kidney problems
- ☐ Dialysis

- [ ] Liver disease
- [ ] Fevers or swollen glands
- [ ] Low sugar (hypoglycemia)
- [ ] Skin diseases
- [ ] Thyroid disorders
- [ ] Lupus
- [ ] Syphilis or venereal disease
- [ ] Mononucleosis (Epstein Barr)
- [ ] Lyme disease
- [ ] Meningitis
- [ ] Tuberculosis (TB)

Eye Problems

- [ ] Crossed eyes, lazy eye
- [ ] Poor vision in one eye (amblyopia)

Neurological Problems

- [ ] Bladder problems
- [ ] Tremor or incoordination
- [ ] Problems with sexual function
- [ ] Trouble speaking
- [ ] Loss of consciousness (faints or seizures)
- [ ] Pins and needles, numbness (where) dfg
- [ ] Muscle weakness (where) hh

Surgeries

- [ ] Appendix
- [ ] Breast
- [ ] Cataract
- [ ] Carotid
- [ ] C-Section
- [ ] Ear
- [ ] Gall Bladder
- [ ] Hysterectomy
- [ ] Prostate
- [ ] Sinus
- [ ] Stomach
- [ ] Tonsils
- [ ] Other

LIFE STYLE - HABITS

How many alcoholic drinks per week ? [ ] None [ ]

Do you smoke cigarettes, cigars or pipes ? [ ] No [ ] Yes

How many caffeinated drinks per day? [ ] None [ ] More than 4

Do you have regular sleep/wake patterns ? [ ] No [ ] Yes

Do you salt your food? [ ] No [ ] Moderate [ ] Lots

Are you currently involved in litigation with respect to any medical problems ? [ ] No [ ] Yes

Are you usually highly stressed? [ ] No [ ] Yes

Do you usually eat 3 meals/day? ☐ No ☐ Yes

INJURIES (Check and date)

- ☐ Head date
- ☐ Neck (for example whiplash) date
- ☐ Dental work preceding onset of headache date

EXPOSURES OR INFECTIONS: (Check and date)

- ☐ Carbon Monoxide (car or house) date
- ☐ Tuberculosis or Cysticercosis date
- ☐ History of meningitis date

FAMILY HISTORY

Are there any **family members** with:

- ☐ Stroke
- ☐ Diabetes
- ☐ Heart disease or high blood pressure
- ☐ Migraine headaches
- ☐ Other diseases that run in the family (list)

GENERAL MEDICAL TESTS

- ☐ Recent general medical checkup? Date:
- ☐ Recent blood tests (Glucose, blood count) Date:
- ☐ Heart test (EKG, Stress test, Holter Monitor) Date: