Dizziness / Vertigo Pre-Visit Evaluation

Please complete this form and bring it with you to your first visit

Date: ___________ Name: ______________________________________

FOR EACH OF THE FOLLOWING ITEMS, PLEASE PLACE A CHECK MARK [✓] IN THE APPROPRIATE COLUMN	YES	NO	SOMETIMES
Does looking up increase your problem?			
Does your problem make you feel frustrated?			
Does your problem cause you to restrict travel for business or recreation?			
Does walking down the aisle of a supermarket increase your problem?			
Do you have difficulty getting into or out of bed because of your problem?			
Does your problem significantly restrict your participation in social activities?			
Does bending over increase your problem?			
Are you afraid to leave home because of your problem?			
Does turning over in bed increase your problem?			
Does walking down a sidewalk increase your problem?			
Do you avoid heights because of your problem?			
Does your problem interfere with your job or household responsibilities?			
Are you depressed because of your problem?			
Do you feel handicapped because of your problem?			
Do you feel embarrassed in front of others because of your problem?			
Is it difficult to walk around your house in the dark because of your problem?			

TO HELP US UNDERSTAND YOUR PROBLEM PLEASE CHECK THE APPROPRIATE RESPONSE TO THE ITEMS BELOW
How long ago did you first experience this problem? Days Weeks Months Years
How long have you been consistently experiencing this problem? Days Weeks Months Years
Which best describes the pattern in which your dizzy/vertigo spells occur? Constant Occurs in Attacks
How frequently do you have dizzy/vertigo spells? [check the one that best describes your problem] Daily Weekly Monthly Many times/day Many times/month

PLACE A CHECK MARK [✓] TO THE LEFT OF THE ITEM WHICH BEST DESCRIBES WHEN YOUR PROBLEM OCCURS					
	At night		In the Daytime		Both Day & Night
	Only at night		Only during the day		Various times/all the time

PLACE A CHECK MARK [✓] TO THE LEFT OF THE ITEM WHICH BEST DESCRIBES THE STATUS OF YOUR PROBLEM					
	Stable [no recent change]		Persistent		Improving
	Worsening*		Completely resolved		

***If your condition has been worsening,** for how long? [check one] **Days** **Weeks** **Months**

PLACE A CHECK MARK [✓] TO THE LEFT OF ALL OF THE ITEMS BELOW WHICH RELIEVE YOUR PROBLEM					
	Nothing		Being still		Meclizine/Antivert
	Steroids		Other [describe]:		

PLACE A CHECK MARK [✓] TO THE LEFT OF THE ITEMS YOU THINK MAY CAUSE/BRING ON THE PROBLEM					
	Nothing		Head Injury		Riding in a boat
	Turning my head		Allergies		Rolling over in bed
	Riding in a car		Stress		Flying
	Caffeine		Migraines		Standing up suddenly
	Turning/changing position		Coughing		High salt diet
	Fever		Other [describe]:		

PLACE A CHECK MARK [✓] TO THE LEFT OF THE ITEMS THAT DESCRIBE YOUR PROBLEM					
	General loss of balance		Loss of consciousness		Tendency to fall to the right
	Tendency to fall forward		Tendency to fall backward		Feeling of objects spinning
	Pressure in the head		Lightheadedness		Swimming sensation
	Sensation of turning/spinning		Loss of balance when walking & veering to the right		
			Loss of balance when walking & veering to the left		
	Other [describe]:				

PLACE A CHECK MARK [✓] TO THE LEFT OF ALL ITEMS WHICH YOU HAVE EXPERIENCED IN RELATION TO OR WITH YOUR DIZZY/VERTIGO SPELLS					
	Cold sweats [diaphoresis]		Fever		Fluctuating hearing loss
	Consistent loss of hearing		Headache		Ear infections
	Ringing in the ear [tinnitus]		Nausea		Blurred vision
	Anxiety		Neurological disease		Difficulty speaking
	Depression		Recent head trauma		Difficulty swallowing
	Diabetes mellitus		Fainting [syncope]		Weakness in arms/legs
	Double vision [diplopia]		Vomiting		Fullness in the ears
	Facial numbness/paralysis		Stress		Clumsiness in arms/legs
	Confusion		Loss of consciousness		Pain in neck/shoulders
	Other [describe]:				

PLACE A CHECK MARK [✓] TO THE LEFT OF ALL OF THE MEDICATIONS WHICH YOU HAVE TAKEN IN THE PAST							
	Diuretics [fluid pills]		Hypertensives		Aspirin		Coumadin
	Sedatives		Narcotics		Benzodiazepines		Antihistamines
	Steroids		Meclizine/Antivert		Other [describe]:		

PLACE A CHECK MARK [✓] TO THE LEFT OF ALL OF THE EVALUATIONS/THERAPIES YOU HAVE HAD					
	Dizziness Rehabilitation		Low salt diet		Neurology consults
	Cardiology consult		I have had no evaluations or therapy for this problem		
	Other [describe]:				

The success of previous medications, evaluations and therapies for the problem has been:

Excellent Minimal Negligible None Short Term

PLEASE DESCRIBE:

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PLACE A CHECK MARK [✓] TO THE LEFT OF ALL OF THE DIAGNOSTIC TESTS YOU HAVE HAD IN THE PAST					
	I have had no tests		Dix-Hallpike Maneuver		ENG
	CT Scan of head/brain		MRI of head/brain		
	Other [describe]:				

Place a check mark [✓] in the appropriate column to indicate if you have experienced any of the following symptoms. If you have, please indicate if each is CONSTANT or occurs IN EPISODES	YES	NO	CONSTANT	IN EPISODES
Double vision				
Numbness of the face or extremities [arms/legs/feet/hands]				
Blurred vision or blindness				
Weakness in arms or legs				
Clumsiness in arms or legs				
Confusion or loss of consciousness				
Difficulty with speech				
Difficulty with swallowing				
Pain in the neck				

Please list the medications (including vitamins) which you are currently taking:

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