

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? <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years
How long have you been consistently experiencing this problem? <input type="checkbox"/> Days <input type="checkbox"/> Weeks <input type="checkbox"/> Months <input type="checkbox"/> Years
Which best describes the pattern in which your dizzy/vertigo spells occur? <input type="checkbox"/> Constant <input type="checkbox"/> Occurs in Attacks
How frequently do you have dizzy/vertigo spells? [check the one that best describes your problem] <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Many times/day <input type="checkbox"/> Many times/month

PLACE A CHECK MARK [✓] TO THE LEFT OF THE ITEM WHICH BEST DESCRIBES WHEN YOUR PROBLEM OCCURS

<input type="checkbox"/>	At night	<input type="checkbox"/>	In the Daytime	<input type="checkbox"/>	Both Day & Night
<input type="checkbox"/>	Only at night	<input type="checkbox"/>	Only during the day	<input type="checkbox"/>	Various times/all the time

PLACE A CHECK MARK [✓] TO THE LEFT OF THE ITEM WHICH BEST DESCRIBES THE STATUS OF YOUR PROBLEM

<input type="checkbox"/>	Stable [no recent change]	<input type="checkbox"/>	Persistent	<input type="checkbox"/>	Improving
<input type="checkbox"/>	Worsening*	<input type="checkbox"/>	Completely resolved	<input type="checkbox"/>	

*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

<input type="checkbox"/>	Nothing	<input type="checkbox"/>	Being still	<input type="checkbox"/>	Meclizine/Antivert
<input type="checkbox"/>	Steroids	<input type="checkbox"/>	Other [describe]:		

PLACE A CHECK MARK [✓] TO THE LEFT OF THE ITEMS YOU THINK MAY CAUSE/BRING ON THE PROBLEM

<input type="checkbox"/>	Nothing	<input type="checkbox"/>	Head Injury	<input type="checkbox"/>	Riding in a boat
<input type="checkbox"/>	Turning my head	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Rolling over in bed
<input type="checkbox"/>	Riding in a car	<input type="checkbox"/>	Stress	<input type="checkbox"/>	Flying
<input type="checkbox"/>	Caffeine	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	Standing up suddenly
<input type="checkbox"/>	Turning/changing position	<input type="checkbox"/>	Coughing	<input type="checkbox"/>	High salt diet
<input type="checkbox"/>	Fever	<input type="checkbox"/>	Other [describe]:		

PLACE A CHECK MARK [✓] TO THE LEFT OF THE ITEMS THAT DESCRIBE YOUR PROBLEM

<input type="checkbox"/>	General loss of balance	<input type="checkbox"/>	Loss of consciousness	<input type="checkbox"/>	Tendency to fall to the right
<input type="checkbox"/>	Tendency to fall forward	<input type="checkbox"/>	Tendency to fall backward	<input type="checkbox"/>	Feeling of objects spinning
<input type="checkbox"/>	Pressure in the head	<input type="checkbox"/>	Lightheadedness	<input type="checkbox"/>	Swimming sensation
<input type="checkbox"/>	Sensation of turning/spinning	<input type="checkbox"/>	Loss of balance when walking & veering to the right		
<input type="checkbox"/>		<input type="checkbox"/>	Loss of balance when walking & veering to the left		
<input type="checkbox"/>	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

<input type="checkbox"/>	Cold sweats [diaphoresis]	<input type="checkbox"/>	Fever	<input type="checkbox"/>	Fluctuating hearing loss
<input type="checkbox"/>	Consistent loss of hearing	<input type="checkbox"/>	Headache	<input type="checkbox"/>	Ear infections
<input type="checkbox"/>	Ringing in the ear [tinnitus]	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	Blurred vision
<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Neurological disease	<input type="checkbox"/>	Difficulty speaking
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Recent head trauma	<input type="checkbox"/>	Difficulty swallowing
<input type="checkbox"/>	Diabetes mellitus	<input type="checkbox"/>	Fainting [syncope]	<input type="checkbox"/>	Weakness in arms/legs
<input type="checkbox"/>	Double vision [diplopia]	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	Fullness in the ears
<input type="checkbox"/>	Facial numbness/paralysis	<input type="checkbox"/>	Stress	<input type="checkbox"/>	Clumsiness in arms/legs
<input type="checkbox"/>	Confusion	<input type="checkbox"/>	Loss of consciousness	<input type="checkbox"/>	Pain in neck/shoulders
<input type="checkbox"/>	Other [describe]:				

PLACE A CHECK MARK [✓] TO THE LEFT OF ALL OF THE MEDICATIONS WHICH YOU HAVE TAKEN IN THE PAST

<input type="checkbox"/>	Diuretics [fluid pills]	<input type="checkbox"/>	Hypertensives	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	Coumadin
<input type="checkbox"/>	Sedatives	<input type="checkbox"/>	Narcotics	<input type="checkbox"/>	Benzodiazepines	<input type="checkbox"/>	Antihistamines
<input type="checkbox"/>	Steroids	<input type="checkbox"/>	Meclizine/Antivert	<input type="checkbox"/>	Other [describe]:		

PLACE A CHECK MARK [✓] TO THE LEFT OF ALL OF THE EVALUATIONS/THERAPIES YOU HAVE HAD

<input type="checkbox"/>	Dizziness Rehabilitation	<input type="checkbox"/>	Low salt diet	<input type="checkbox"/>	Neurology consults
<input type="checkbox"/>	Cardiology consult	<input type="checkbox"/> I have had no evaluations or therapy for this problem			
<input type="checkbox"/>	Other [describe]:				

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

Excellent
 Minimal
 Negligible
 None
 Short Term

PLEASE DESCRIBE:

PLACE A CHECK MARK [✓] TO THE LEFT OF ALL OF THE DIAGNOSTIC TESTS YOU HAVE HAD IN THE PAST

<input type="checkbox"/>	I have had no tests	<input type="checkbox"/>	Dix-Hallpike Maneuver	<input type="checkbox"/>	ENG
<input type="checkbox"/>	CT Scan of head/brain	<input type="checkbox"/>	MRI of head/brain	<input type="checkbox"/>	
<input type="checkbox"/>	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:
