



HEALTH HISTORY FORM

Name: _____ D.O.B.: _____ Date: _____

I. CHIEF CONCERN - Please check all the symptoms you are currently experiencing below:

- o Dizziness o Lightheadedness o Vertigo (spinning) o Blacking out or fainting o Other: _____
o Imbalance o Unsteadiness o Falling o Sudden "drop attacks" o Other: _____

Describe in your own words how your dizziness or imbalance problem feels:

II. HISTORY OF PRESENT ILLNESS

A. DESCRIBE THE NATURE OF YOUR PROBLEM:

- 1. When did your problem start? (date) _____ Was there any related event? -> O Yes O No
a. If yes, check all that apply:
o An ear infection
o Common cold
o Auto accident
o Other: _____
2. Was the onset of your problem: o Gradual o Sudden o Overnight o Other: _____
3. It is currently: o Getting better o Staying the same o Getting worse o Variable
a. If variable, rate the severity of your symptoms at the best times ____, and at the worst times ____ (on a scale of 1-10, with 10 being the worst).
4. Do your symptoms limit your daily activities? Please rate the average severity of your symptoms on a scale of 1 to 10 ____ (on a scale of 1-10, with 10 being the worst).
5. Is your dizziness/imbalance: o Constant o or it comes and goes in spells or attacks?
a. If it comes and goes in spells or attacks:
o They occur every # ____ hours ____ days ____ weeks ____ months
o And they last # ____ seconds ____ minutes ____ hours ____ days ____ months
o Do you have any warning the spells or attacks will occur? -> O Yes O No
1. If yes, describe: _____
2. Are you completely free of dizziness/imbalance between spells or attacks? -> O Yes O No
6. Does your dizziness/imbalance occur with position changes? -> O Yes O No
a. If yes, check all that apply:
o Rolling your body right or left
o Going from lying to sitting position
o Looking up, or head back position
o Turning your head left or right
o Bending over, or head down position
7. Do you know of anything that makes your dizziness/imbalance better? -> O Yes O No
a. If yes, check all that apply:
o Not moving my head
o Rest
o Medication: _____
o Other: _____

8. **Do you know of anything that makes your dizziness/imbalance worse?** → O Yes O No
 a. If yes, check all that apply:
 Moving my head
 When in the car or driving
 Large crowds or busy improvements
 When you are hungry or haven't eaten
 Other: _____
9. **Do you have trouble walking in the dark or at dusk?** → O Yes O No
10. **Do you have trouble walking on an uneven surface (eg; lawn) compared to a smooth floor?** → O Yes O No
11. **When you have dizziness or imbalance, must you support yourself to stand or walk?** → O Yes O No
 a. If yes, how do you support yourself? _____
12. **HAVE YOU EVER FALLEN DUE TO YOUR PROBLEM?** → O Yes O No
 a. If yes, describe below:
 # of falls _____ # of "near falls" _____
 Do you tend to fall to the: Right Left Back Forward All
13. **Do you have a history of migraines?** → O Yes O No
14. **For women, is there any relationship between your dizziness and your hormonal cycle?** → O Yes O No
O Not Applicable
15. **Did you recently get new glasses, or has there been a change in your vision?** → O Yes O No
 a. If yes, explain: _____
16. **Have you ever had IV antibiotics** → O Yes O No
17. **Have you ever had chemotherapy** → O Yes O No

B. DO YOU HAVE ANY OF THE FOLLOWING EAR RELATED SYMPTOMS:

1. **Do you have difficulty with hearing?** → O Yes O No
 a. If yes, which ears? Both ears Right ear Left ear
 b. When did this start? _____
2. **Do you wear hearing aides?** → O Yes O No
 a. If yes, which ears? Both ears Right ear Left ear
3. **Do you experience noise or ringing in your ears?** → O Yes O No
 a. If yes, which ears: Both ears Right ear Left ear
 b. Describe the noise: Ringing Buzzing other: _____
 c. Does the noise pulsate or is it steady? Steady Pulsate Variable in volume/intensity
 d. Does anything stop the noise or make it better? → O Yes O No
 Explain: _____
4. **Do you have pain, fullness, or pressure in your ears?** → O Yes O No
 a. If yes, which ears: Both ears Right ear Left ear
 b. Does this coincide with your dizziness/imbalance? → O Yes O No

C. WHILE DIZZY/IMBALANCED, DO YOU EXPERIENCE ANY OF THE FOLLOWING ASSOCIATED SYMPTOMS:

1. **Lightheadedness or floating sensations?** → O Yes O No
2. **Headaches or pressure in your head?** → O Yes O No
3. **Objects or your surroundings spinning or turning around you?** → O Yes O No
4. **A sensation that you are turning or spinning inside, while the objects around you remain stationary?** → O Yes O No
5. **When you are walking, do you:** Veer to the right Veer to the left Both directions ?
6. **Nausea or vomiting?** → O Yes O No
7. **Tingling of hands, feet, or lips?** → O Yes O No

D. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING SYMPTOMS? INDICATE IF CONSTANT OR EPISODIC:

YES	NO					Comments:	
		1. Double/blurred vision or blindness		Constant		In episodes	
		2. Numbness of face or extremities		Constant		In episodes	
		3. Weakness in arms and legs		Constant		In episodes	
		4. Clumsiness in arms and legs		Constant		In episodes	
		5. Confusion or loss of consciousness		Constant		In episodes	
		6. Difficulty with speech or swallowing		Constant		In episodes	

E. PLEASE NOTE ANY PRIOR RELEVANT MEDICAL EVALUATIONS, DIAGNOSTIC TESTING, AND TREATMENT:

- Have you seen other healthcare providers for this problem? → **O Yes O No**
 - If yes, who: Primary care ER ENT Neurologist Cardiologist Other: _____
- Have you had tests done for this problem elsewhere? → **O Yes O No**
 - ENG/VNG Where: _____ When: _____ Results: _____
 - MRI/CT Where: _____ When: _____ Results: _____
 - Hearing tests Where: _____ When: _____ Results: _____
 - Other: Where: _____ When: _____ Results: _____

III. PERSONAL HEALTH HISTORY

A. HAVE YOU EVER HAD ANY OF THE FOLLOWING?

- Serious injuries/illnesses:** → **O Yes O No**
 - If yes, please list and give approximate dates:
 - Due to dizziness or imbalance: _____
 - Unrelated to current problem: _____
- Surgeries:** → **O Yes O No**
 - If yes, please list with dates:
 - _____
 - _____
- Hospitalizations:** → **O Yes O No**
 - If yes, please list with dates
 - _____
 - _____
- Women only:**
 - Have you ever been pregnant? → **O Yes O No**
 - If yes, note delivery dates: _____
 - Are you pregnant now? → **O Yes O No**
 - If yes, what is your due date: _____

IV. MEDICATIONS

- Are you currently taking any medications? If yes, please list below → **O Yes O No**

PRESCRIPTIVE MEDICATIONS:	Dose/Strength	Times/day	For how long?

OVER THE COUNTER MEDICATIONS:						
Aspirin		YES		NO		
NSAID (Advil, Aleve)		YES		NO		
Vitamins (what?)		YES		NO		
Others?						

V. ALLERGIES

1. **Do you have any allergies or sensitivities to medications?** → O Yes O No
 a. *If yes*, please note medications/reactions: _____

2. **Do you have any other allergies?** → O Yes O No
 b. *If yes*, please note allergen/reactions: _____

VI. PAST AND FAMILY MEDICAL HISTORY

Please indicate in the table below which conditions you and/or your family members have had:

	<u>SELF</u>	Mother	Father	Sister	Brother
Alzheimer's					
Anemia(note type)					
Anxiety					
Arrhythmia(irreg.pulse)					
Arthritis					
Asthma					
Auto-immune disease					
Blood Clots					
Cancer (note Type)					
Cataracts					
Depression					
Diabetes (note Type)					
Drug or alcohol abuse					
Epilepsy/Seizures					
Fibromyalgia					
Glaucoma					
"Hardened arteries"					
Heart Disease					
High Blood Pressure					
High Cholesterol					
Macular degeneration					
Migraine headaches					
Multiple sclerosis					
Osteoporosis					
Panic attacks					
Parkinson's					
Sleep Apnea					
Stroke or TIAs("mini")					
Thyroid disease					
Tumors(ear,head)					
Other:					

VII. SOCIAL HISTORY/LIFESTYLE:

1. **Marital status:** Single Married Divorced/separated Partner Widowed Re-married
2. **Occupation:** _____ **Current Status:** Full-time Part-time On leave Unemployed Retired
3. **Education level completed:** High school GED/equivalent Some college Undergrad degree Grad degree
4. **Your current living situation:** House Apartment Assisted living Senior home Other: _____
5. **Who do you live with?** Spouse Family Alone Other: _____

Please indicate your current level of activity, and activity prior to developing your problem:

CURRENTLY		PRIOR TO PROBLEM	
Activity level	List Activities/Hobbies	Activity level	List Activities/Hobbies
Inactive		Inactive	
Light		Light	
Moderate		Moderate	
Vigorous		Vigorous	

1. **If your activity level is low, what are the major barriers? (check all that apply)**

- Dizziness
- Imbalance
- Fear of falling
- Lack of energy or stamina
- Pain and/or discomfort, where/what? _____
- Other: _____

IX. HABITS

1. **Smoking habits:**

- Non-smoker
- Smoker, I currently smoke _____ packs a day
- Ex-smoker, I quit smoking (date) _____

2. **Alcohol use:**

- I don't drink alcohol
- I drink alcohol. I currently drink _____ drinks per day usually of _____
- I drink alcohol. I currently drink _____ drinks per week usually of _____
- I drink alcohol. I currently drink _____ drinks per month usually of _____

3. **Caffeine use:**

- I don't consume caffeine
- I drink caffeinated beverages _____ times a day
- I drink caffeinated beverages _____ times a week
- I drink caffeinated beverages _____ times a month
-
- Other: _____

4. **Recreational drug use:**

- I don't use drugs
- I use _____ How many times/day? _____ for how long? _____

III. REVIEW OF SYSTEMS

Do you now or have you had recurrent problems with the following symptoms?

GENERAL/ENDOCRINE:

Excess hunger or thirst		NO	YES
Fatigue		NO	YES
Fevers, chills, sweats		NO	YES
Fluid retention		NO	YES
Hypoglycemia/low blood sugar		NO	YES
Lack of appetite		NO	YES
Weakness, generalized		NO	YES

Notes: _____

HEENT (HEAD,EYES,EARS,MOUTH,NOSE AND THROAT):

Allergies/hay fever		NO	YES
Blurred vision		NO	YES
Ear pain		NO	YES
Headaches		NO	YES
Hearing problems		NO	YES
Nasal congestion		NO	YES
Ringing in ears		NO	YES
Sinus infections(chronic)		NO	YES

Notes: _____

LUNGS-RESPIRATORY:

Cough		NO	YES
Short of breath		NO	YES
Wheezing		NO	YES

Notes: _____

HEART-CARDIOVASCULAR:

Chest Pain		NO	YES
History of murmur		NO	YES
Irregular or racing heartbeat		NO	YES
Lightheaded on arising quickly		NO	YES
Poor circulation		NO	YES

Notes: _____

NEUROLOGICAL-PSYCHIATRIC:

Claustrophobia		NO	YES
Confusion		NO	YES
Coordination problems		NO	YES
Insomnia (can't sleep)		NO	YES
Memory Loss		NO	YES
Numbness, tingling		NO	YES
Stressed		NO	YES
Tremor		NO	YES
Walking difficulty or disorder			

Notes: _____

ADOMINAL/GASTROINTESTINAL:

Abdominal pain		NO	YES
Black or bloody stools		NO	YES
Constipation or diarrhea		NO	YES
Heartburn, reflux, ulcers		NO	YES
Liver disease or jaundice		NO	YES
Nausea, Vomiting		NO	YES

Notes: _____

GENITO-URINARY:

Involuntary loss of urine		NO	YES
Urinary infections		NO	YES

Notes: _____

FEMALES:

Infertility		NO	YES
Irregular cycle		NO	YES
Menopause symptoms		NO	YES
PMS		NO	YES

Notes: _____

BONES/JOINTS/EXTREMITIES/MUSCULOSKELETAL

Aching muscles		NO	YES
Back pain ,disc disease		NO	YES
Foot pain/problems		NO	YES
Joint pain or stiffness		NO	YES
Leg cramps or spasms		NO	YES
Leg swelling		NO	YES
Neck pain or stiffness		NO	YES
Need assistive device to walk (walker, cane, etc.)		NO	YES
Need wheelchair		NO	YES

Notes: _____

SKIN:

Easy bruising		NO	YES
Rashes or open sores		NO	YES

Notes: _____

Comments: _____

