Corwin's Therapeutics
Vestibular Medical Questionaire

Patient:_____ **Date:**_____

Complaint:_____

_____

Vestibular problems can cause a wide range of symptoms and patients may describe them in different ways. Many respondents added the following descriptions to the list of symptoms they have experienced:

Anxiety
Buzzing Sensation
Clumsiness
Confusion
Constant hung-over feeling
Difficulty looking down
Difficulty reading
Eyes twitching or jumping
Difficulty Swallowing
Dizziness in rooms where lots of people are talking.
Dream related dizziness
Dream like state
Eye Pain
Fatigue
Feeling like on a roller coaster.
Feeling like just got off a roller coaster.
Feelings of off balance
Flush/Sweating feeling
Head Pressure
Headaches
Hyperacusis (abnormal acute hearing)
Light sensitivity
Short-term memory loss
Strange sensation of floor moving.
Unable to lay on one side without spinning.

IS DIZZINESS PRESENT:

1. **When you turn your head left or right quickly.**
2. **Roll over in bed.**
3. **Get up too quickly.**
4. **Bend and look down.**
5. **Reach and look up.**

Have your carotid arteries been checked? YES or NO

Blood Pressure:_____

Last Eye Exam:_____

Last Hearing Evaluation:_____

Do you have numbness or tingling in any part of your body? YES or NO

Approximately when did the first signs or symptoms begin?_____

_____

_____

Name _____

Please describe your dizziness problem: _____

Does it make you feel light-headed? _____ Faint? _____

Do you feel as if you are moving or as if the world is moving around you? _____

Does the movement seem to be right or left? _____

How frequently do you experience this problem (daily, weekly, etc): _____

How long does each episode last? (seconds, minutes, hours) _____

Do you incur any other symptoms beyond the dizziness? i. e, ringing in the ears, ear fullness, etc.

_____

If you have fallen due to your dizziness please tell us which direction you have fallen: _____

Has the dizziness caused you nausea? _____

Does anything make it better or worse? _____

How severe do you feel the problem is: _____

Does it keep you from doing normal activities: (i.e. can't drive, can't gocery shop or go to the mall, do you have to lay down?)_____

Please provide us with a listing of medications (*include over the counter medications you are taking)

_____

_____

Have you been in an accident in which you incurred a head or neck injury? _____
Do you have or have you had any of the following medical problems:

Yes	No	Diabetes	Yes	No	Hypertension
Yes	No	Alcoholism	Yes	No	Heart Disease
Yes	No	Allergies	Yes	No	Immune system
Yes	No	Cancer	Yes	No	Circulatory System
Yes	No	Depression	Yes	No	Mental Illness
Yes	No	Hormonal Problems	Yes	No	Pregnancy
Yes	No	Stroke	Yes	No	Epilepsy
Yes	No	Hearing Loss	Yes	No	Vision Problems

Yes No Seizures-if you answered yes to this question please answer the following:

How many seizures have you experienced? _____ For how long? _____

What have you had done to correct this problem? _____

Have you had a CT Scan of the brain? _____ When? _____

Have you had a MRI? _____ Who ordered this test? _____

Is there anything pertaining to this illness that you feel we should know other than the questions we have covered?

_____

I certify that I have read and understand the above. I will not hold the program or any of its staff responsible for any error or omissions that I have made in completion of the form.

_____ _____

PATIENT SIGNATURE DATE