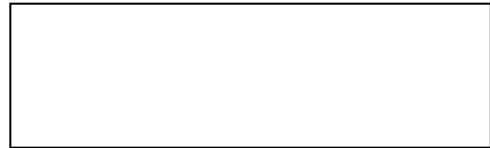

UCSF Medical Center

VESTIBULAR HISTORY

Name: ______________________________ **Date of Birth:** _______________ **Age:** _______

Today's Date: _________________________ **Phone number** ___________________________

Referring MD _________________________ **Next MD Appt:** ___________________________

Briefly describe your problem:

____

____

____

____

Describe:

Date of onset: __________________________ Time of day: _____________________________

What were you doing when it began? ____

What were the first symptoms? ____

How long did these symptoms last?

__Seconds ___ Minutes ___ Hours ___ Days ____ Constant

Have you had more than one episode of dizziness? ____ Yes ____ No

If yes, how often do these episodes occur? ____

No, skip to Page 2

Since the first episode, are they becoming more or less frequent or no change?

___ More frequent ___ Less frequent ___ No Change ___ N/A

Since the first episode, are they becoming more or less severe or no change?

___ More severe ___ Less severe ___ No Change ___ N/A

Have you experienced nausea and/or vomiting? __ Yes __ No

Describe anything that will stop the dizziness or make it better:______________________________

Describe anything that makes the dizziness worse:_______________________________________

Does anyone else in your family have problems with dizziness?:______________________________

When you are dizzy do you experience:

___ Difficulty with speech
___ Confusion
___ Spots, wavy lines or colored lights in vision
___ Numbness, where? ________________
___ Weakness in arms or legs
___ Tingling around your mouth
___ Blurred vision or blindness
___ Difficulty with swallowing

Ear and Hearing History (check any that apply)

Loss of hearing:	___ Right	___ Left
Tinnitus (noise in your ear(s)):	___ Right	___ Left
Pressure/fullness in your ear(s):	___ Right	___ Left
Ear infections, earaches or ear pain:	___ Right	___ Left
Hole in your eardrum:	___ Right	___ Left
Ear operations/surgery:	___ Right	___ Left

Please describe: ____

Have you experienced loud noise exposure in the past?	___ Yes	___ No
Does your hearing fluctuate with dizzy episodes?	___ Yes	___ No

Lifestyle Questions

Do you drink alcohol? ___ Yes ___ No

If yes, how many drinks per day? ______________________________

Do you smoke? ___ Yes ___ No

If yes, how many cigarettes per day? ______________________________

Do you consume caffeinated beverages? ___ Yes ___ No

If yes, how many cups per day?

Do you exercise? ___ Yes ___ No

If yes, how many times a week and for how long? ______________________________

Medications

Please attach a list of all your current medications, including hormones, birth control pills, vitamins, etc. Please include the name of the medication, dosage and times per day taken.

What medications have you taken specifically for your dizziness? ______________________________

List any medication allergies:

____

Past Medical History

Please check those items you have experienced and date of any treatment:

		Treatment Date			Treatment Date
___	Low back pain	________	___	Loss of vision	________
___	Neck pain	________	___	HIV/AIDS	________
___	Loss of feeling in feet	________	___	Heart attack	________
___	Ankle sprain/fracture	________	___	Cardiac surgery	________
___	Neck injury	________	___	TMJ	________
___	Knee/Hip injury	________	___	Recent dental work	________
___	Eye problems	________	___	Stroke	________
___	Concussion	________	___	Seizure	________
___	Head injury	________	___	High cholesterol	________
___	High cholesterol	________	___	Unusual stress	________
___	Headaches	________	___	Panic attacks	________
___	Migraines	________	___	Treatment by psychologist	________
___	Diabetes	________	___	Treatment by psychiatrist	________
___	Low blood sugar	________	___	Depression	________

Previous Medical Tests

Check all that apply. Please include the date of test, where the test was performed and the results of the testing if you know them (indicate by item number):

___ 1. Hearing test
___ 2. ENG (Electronystagmography) or VNG (Videonystagmography)
___ 3. MRI of brain (Magnetic Resonance Imaging
_____ with contrast
_____ without contrast
___ 4. MRI of ears
_____ with contrast
_____ without contrast
___ 5. MRA (Magnetic Resonance Angiography)
___ 6. CT Scan of brain
___ 7. CT Scan of ears
___ 8. ABR (Auditory Brainstem Response/Brainstem Auditory Evoked Response)
___ 9. Balance Platform Test (Posturography)
___ 10. Rotary Chair Test
___ 11. VAT (Vestibular Autorotation Test)
___ 12. ECOG (Electrocochleography)
___ 13. EEG (Electroencephalogram)
___ 14. EKG (Electrocardiogram)
___ 15. Holter monitor testing for irregular heartbeat
___ 16. Neck X-rays
___ 17. Neurology Evaluation
___ 18. Lumbar Puncture (Spinal Fluid Study)
___ 19. Complete Physical Examination

Item Number: ____________ Test Date: __________ Test Location: ________________________
Test Results: ____

Item Number: ____________ Test Date: __________ Test Location: ________________________
Test Results: ____

Item Number: ____________ Test Date: __________ Test Location: ________________________
Test Results: ____

Item Number: ____________ Test Date: __________ Test Location: ________________________
Test Results: ____

Item Number: ____________ Test Date: __________ Test Location: ________________________
Test Results: ____

Rev. 09/12

UCSF Medical Center

AUDIOLOGY | **DIZZINESS HANDICAP INVENTORY**

Name: ______________________________ **Date:** ____________

Reason for visit: ______________________________

Instructions: The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your dizziness. Please answer every question. Please do not skip any questions.

	Question			
1.	Does looking up increase your problem?	Yes	Sometimes	No
2.	Because of your problem, do you feel frustrated?	Yes	Sometimes	No
3.	Because of your problem, do you restrict your travel for business or recreation?	Yes	Sometimes	No
4.	Does walking down the aisle of a supermarket increase your problem?	Yes	Sometimes	No
5.	Because of your problem, do you have difficulty getting into or out of bed?	Yes	Sometimes	No
6.	Does your problem significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing, or to parties?	Yes	Sometimes	No
7.	Because of your problem, do you have difficulty reading?	Yes	Sometimes	No
8.	Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem?	Yes	Sometimes	No
9.	Because of your problem, are you afraid to leave home without having someone with you?	Yes	Sometimes	No
10.	Because of your problem, have you been embarrassed in front of others?	Yes	Sometimes	No
11.	Do quick movements of your head increase your problem?	Yes	Sometimes	No
12.	Because of your problem, do you avoid heights?	Yes	Sometimes	No
13.	Does turning over in bed increase your problem?	Yes	Sometimes	No
14.	Because of your problem, is it difficult for you to do strenuous housework or yard work?	Yes	Sometimes	No
15.	Because of your problem, are you afraid people may think you are intoxicated?	Yes	Sometimes	No
16.	Because of your problem, is it difficult for you to go for a walk by yourself?	Yes	Sometimes	No
17.	Does walking down a sidewalk increase your problem?	Yes	Sometimes	No
18.	Because of your problem, is it difficult for you to concentrate?	Yes	Sometimes	No
19.	Because of your problem, is it difficult for you to go for a walk around your house in the dark?	Yes	Sometimes	No
20.	Because of your problem, are you afraid to stay home alone?	Yes	Sometimes	No
21.	Because of your problem, do you feel handicapped?	Yes	Sometimes	No
22.	Has your problem placed stress on your relationship with members of your family or friends?	Yes	Sometimes	No
23.	Because of your problem, are you depressed?	Yes	Sometimes	No
24.	Does your problem interfere with your job or household responsibilities?	Yes	Sometimes	No
25.	Does bending over increase your problem?	Yes	Sometimes	No

Reference: The Development of the Dizziness Handicap Inventory Gary P. Jacobson, Ph.D.; Craig W. Newman, Ph.D. *Arch Otolaryngol Head Neck Surg.* 1990; 116(4):424–427

Patient Name: ___________________________

Date of Birth: ___________________________

Medical Record Number: ___________________________

Please list all Doctors/Providers who referred you here, your primary care doctor, and any other doctor from whom you are receiving care. This information is required:

Doctor who sent you to see us:____________________________

Specialty: ___________________

Street Address: ______________________________ City: _______________ State: _____

Phone: (___) __________________________ Fax: (___) _____________________________

Primary Care Doctor/Provider: ____

Street Address: ______________________________ City: _______________ State: _____

Phone: (___) __________________________ Fax: (___) _____________________________

Additional Doctors/Providers/Agencies I would like my visit report sent to:

____

Street Address: ______________________________ City: _______________ State: _____

Phone: (___) __________________________ Fax: (___) _____________________________

Additional Doctors/Providers/Agencies I would like my visit report sent to:

____

Street Address: ______________________________ City: _______________ State: _____

Phone: (___) __________________________ Fax: (___) _____________________________

Additional Doctors/Providers/Agencies I would like my visit report sent to:

____

Street Address: ______________________________ City: _______________ State: _____

Phone: (___) __________________________ Fax: (___) _____________________________