NATIONAL DIZZY & BALANCE CENTER
HEALTH HISTORY FORM

COMPLETE USING BLACK INK ONLY

Name: _____ Date of Birth: _____ Appointment Date: _____

I. CHIEF COMPLAINT

1. What symptoms are you currently experiencing? (check all that apply)

□ Dizziness □ Imbalance □ Hearing Difficulty □ Visual Difficulty □ Headache / Migraine

□ Vertigo / Spinning □ Unsteadiness □ Ear Pain / Pressure □ Cognitive Difficulty □ Nausea / Vomiting

□ Lightheadedness □ Falling □ Ringing in Ears □ Anxiety □ Blacking out / Fainting

□ Other (please describe): _____

II. HISTORY OF PRESENT ILLNESS

1. When did your problem start? _____. Was the onset: □ Gradual or □ Sudden?

2. Was there any related event? □ Yes □ No – If yes, check all that apply:

□ Ear Infection / Cold or Flu □ Auto / Work-Related Accident □ Other (please describe below):

_____

3. Is your problem currently: □ Getting better □ Getting worse □ Staying the same or □ Variable?

4. Rate the average severity of your symptoms on a scale of 1 to 10 (10 being the worst): _____.

5. How would you rate your symptoms at best 1 to 10 (10 being the worst): _____ **At your worst:** _____

6. Is your problem: □ Constant or □ It comes and goes in spells / attacks that occur every:

□ ___ Hours □ ___ Days □ ___ Weeks, **and last for** □ ___ Seconds □ ___ Minutes □ ___ Hours □ __ Days

7. Does your problem occur with position changes? □ Yes □ No – If yes, check all that apply:

□ Rolling your body right and left □ Looking up or head back □ Bending over or head down

□ Going from lying to sitting □ Going from sitting to standing □ Turning head left / right

8. Does anything make your problem better? □ Yes □ No – If yes, check all that apply:

□ Limiting head movement □ Rest / Sleep □ Closing your eyes □ Other (please describe below):

_____

9. Does anything make your problem worse? □ Yes □ No – If yes, check all that apply:

□ Head movement □ Physical Activity □ Large crowds / Busy environments □ Other (please describe below):

_____

10. Does your problem involve any of the following associated symptoms? (check all that apply)

□ Numbness or tingling of hands / feet / lips □ Double / Blurred vision □ Weakness / Clumsiness in arms or legs

11. Does your problem make it difficult to walk or stand without assistance? □ Yes □ No

12. Do you have a history of falling? □ Yes □ No **How many falls in the past year?** _____

13. When you are walking, do you: □ Veer right □ Veer left □ Veer in both directions?

14. What medical providers have you seen for this problem? (check all that apply)

□ Primary Care □ Emergency Room □ ENT □ Neurology □ Physical Therapy □ Other: _____

15. What tests have been done for this problem? (check all that apply)

□ MRI/CT performed at _____ on _____. Results: _____.

□ Hearing Test performed at _____ on _____. Results: _____.

□ ENG/VNG performed at _____ on _____. Results: _____.

III. PAST SELF AND FAMILY HEALTH HISTORY

1. Please provide a list of serious injuries or illnesses with approximate dates: _____

_____

2. Please provide a list of surgical procedures with approximate dates: _____

_____

3. Have you ever received intravenous (IV) antibiotics? □ Yes □ No
4. Have you ever had a pneumonia vaccination? □ Yes □ No, **If yes, Date:** _____
5. Have you or your family had any of the following problems? (check all that apply)

	Self	Mother	Father
Anemia (note type)			
Anxiety			
Arrhythmia / Irregular Pulse			
Arthritis (note type)			
Auto-Immune Disorder (note type)			
Cancer / Tumors (note type)			
Depression			
Diabetes (note type)			
Epilepsy / Seizures			
Eye Disorder (cataracts / glaucoma)			
Heart Disease			
High or Low Blood Pressure			
High Cholesterol			
Kidney Disease			
Meniere's Disease			
Migraine Headaches			
Multiple Sclerosis			
Parkinson's			
Peripheral Neuropathy			
Stroke or TIAs			
Thyroid Disease (note type)			

IV. CURRENT MEDICATIONS / ALLERGIES (please use the last page of the Health History From or provide a current and complete list of medications, allergies)

V. SOCIAL HISTORY

1. Marital Status (check one): □ Single □ Married □ Divorced □ Widowed □ Other: _____

2. Occupation: _____ **Status:** □ Full time □ Part time □ Retired □ Other: _____

3. Current Living Situation: □ House □ Apartment □ Assisted Living □ Other: _____

4. Who do you live with? □ Alone □ Spouse □ Family □ Other: _____

5. What is your current level of activity? □ Vigorous □ Moderate □ Light □ Inactive

If activity level is low, what barriers do you face? (check all that apply)

□ Fear of Falling □ Lack of Energy / Stamina □ Lack of Time / Effort □ Other (please describe): _____

6. Caffeine Use: □ None □ I drink ___ beverages each day / week / month / year (circle one)

7. Alcohol Use: □ None □ I drink ___ beverages each day / week / month / year (circle one)

8. Tobacco Use: □ Never Smoker, □ Former Smoker, □ Current Smoker

VI. REVIEW OF SYSTEMS

1. Are you <u>currently</u> experiencing any of the following symptoms? (check all that apply)

General	**Yes**	**No**
Fever / Chills / Sweats **(circle)**		
Fatigue		
Lethargy/Weakness **(circle)**		
Sleep Disorder		

Eyes	**Yes**	**No**
Eye Pain		
Blurry Vision / Double Vision **(circle)**		
Vision Loss		
Light Sensitivity		

Ear, Nose & Throat (ENT)	**Yes**	**No**
Hearing Loss / Ringing in the Ear **(circle)**		
Ear Fullness / Pain / Discharge **(circle)**		
Sound Sensitivity		
Nasal Congestion		
Sore Throat / Hoarseness **(circle)**		
Difficulty Swallowing		

Cardiovascular (CV)	**Yes**	**No**
Chest Pain / Discomfort **(circle)**		
Palpitations / Irregular heartbeat **(circle)**		
Syncope (fainting)		
Lightheadedness		

Respiratory	**Yes**	**No**
Cough / Wheezing **(circle)**		
Shortness of Breath		

Gastrointestinal (GI)	**Yes**	**No**
Nausea / Vomiting **(circle)**		
Diarrhea / Constipation **(circle)**		
Heartburn		
Dark Tarry Stools / Bloody Stools **(circle)**		

Genitourinary (GU)	**Yes**	**No**
Frequent Urination / Urine Urgency **(circle)**		
Painful Urination		
Incontinence		

Musculoskeletal (MS)	**Yes**	**No**
Joint Pain / Swelling / Redness **(circle)**		
Stiffness		
Neck Pain / Back Pain **(circle)**		
Morning Stiffness		

Dermatological	**Yes**	**No**
Rash		
Itching		
Skin Cancer – **Type:**		

Neurological	**Yes**	**No**
Numbness / Tingling **(circle)**		
Tremors		
Memory Loss / Confusion **(circle)**		
Poor Balance / Unsteady Gait **(circle)**		
Headaches		
Trouble Speaking		
Seizures		
Change in Sleep Pattern / Insomnia **(circle)**		
Dizziness / Vertigo **(circle)**		

Psych	**Yes**	**No**
Anxiety		
Depression		

Endocrine	**Yes**	**No**
Cold / Heat Intolerance **(circle)**		
Unexplained weight gain / Loss **(circle)**		
Excessive Thirst / Excessive Hunger **(circle)**		

Hematology	**Yes**	**No**
Bleeding Disorders		
Problems with Easy Bruising		
Enlarged Lymph Nodes		

Allergy / Immunologic	**Yes**	**No**
Persistent Infection		
Seasonal Allergies		
HIV Exposure		

NATIONAL DIZZY & BALANCE CENTER
DIZZINESS HANDICAP INVENTORY

PLEASE COMPLETE USING BLACK INK

Name: _____ Date: _____

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer "Yes", "No", or "Sometimes" to each question by circling the corresponding "Y", "N", or "S". Answer each question as it pertains to your dizziness or imbalance only.

P	1.	Does looking up increase your problem?	Y S N
E	2.	Because of your problem, do you feel frustrated?	Y S N
F	3.	Because of your problem, do you restrict your travel for business and/or recreation?	Y S N
P	4.	Does walking down the aisle of a supermarket increase your problem?	Y S N
F	5.	Because of your problem, do you have difficulty getting into or out of bed?	Y S N
F	6.	Does your problem significantly restrict your participation in social activities, such as going out to dinner, movies, dancing, or parties?	Y S N
F	7.	Because of your problem, do you have difficulty reading?	Y S N
P	8.	Does performing more ambitious activities like sports, dancing, and household chores such as sweeping or putting dishes away increase your problem?	Y S N
E	9.	Because of your problem, are you afraid to leave your home without having someone accompany you?	Y S N
E	10.	Because of your problem, have you been embarrassed in front of others?	Y S N
P	11.	Do quick movements of your head increase your problem?	Y S N
F	12.	Because of your problem, do you avoid heights?	Y S N
P	13.	Does turning over in bed increase your problem?	Y S N
F	14.	Because of your problem, is it difficult for you to do strenuous house or yard work?	Y S N
E	15.	Because of your problem, are you afraid people may think you are intoxicated?	Y S N
F	16.	Because of your problem, is it difficult for you to go for a walk by yourself?	Y S N
P	17.	Does walking down a sidewalk increase your problem?	Y S N
E	18.	Because of your problem, is it difficult for you to concentrate?	Y S N
F	19.	Because of your problem, is it difficult for you to walk around your house in the dark?	Y S N
E	20.	Because of your problem, are you afraid to stay home alone?	Y S N
E	21.	Because of your problem, do you feel handicapped?	Y S N
E	22.	Has your problem placed stress on your relationships with members of your family?	Y S N
E	23.	Because of your problem, are you depressed?	Y S N
F	24.	Does your problem interfere with your job or household responsibilities?	Y S N
P	25.	Does bending over increase your problem?	Y S N

Scoring: Y = Yes (4 pts) S = Sometimes (2 pts) N = No (0 pts) Total = _____

Jacobson GP, Newman CW: The development of the Dizziness Handicap Inventory. *Arch Otolaryngol Head Neck Surg* 1990; 116: 424-427

NDBC
National Dizzy & Balance Center

Patient Name Date of Birth

PRESCRIPTION NAME	DOSAGE	FREQUENCY	DRUG FORM (LIQUID, CAPSULTE, ETC)

ALLERGIES	REACTION TYPE: moderate, severe critical