SLENT
HEARING & BALANCE CENTER

PATIENT CASE HISTORY
VESTIBULAR

Date:_____
Patient Name: _____ DOB:_____
Reason for visit: _____
Referred by:_____

Check all that apply.

Characterization/Quality of Symptoms:
□ Lightheadedness □ Unsteadiness □ Spinning □ Turning □ Wooziness
□ Falling: ○backward ○forward ○left ○right □ Faintness □ Tilting / Swaying
□ Difficulty walking □ Loss of Balance □ Shortness of Breath □ Nausea
□ Panic □ Other:_____

When you experience the above symptoms:
Are they sudden? □ Yes □ No
How often do they occur?_____
How are they provoked?_____
When did they begin?_____
How long do they last? □ Seconds □ Minutes □ Days

Are you taking anything for the above symptoms? □ Yes □ No

Exacerbating/Remitting Factors:
Does turning your head bring on or make symptoms worse?
_____
Does laying down or sitting up bring on symptoms or improve them?
_____
Does episode relate to tension or anxiety in your life?
_____
Do you know of anything that will precipitate an attack?
_____
Do you know of anything that will stop or make your symptoms better?
_____

Associated Symptoms:
□ Ringing in ears □ Popping in ears □ Fullness or pressure in ears □ Hearing loss
□ Headache □ Loss of consciousness □ Weakness or numbness of arms/legs/face
□Visual disturbance: ○ wear glasses / contacts ○ eye surgeries?_____

Past/Present Medical History:
□ Head injury □ Ear injury □ Whiplash □ Allergies □ Sinus trouble
□Ear Surgery □ Neck pain □ Back pain □ Thyroid disease □ Stroke
□ Diabetes □ Scuba diving □ Abnormal heart beat □ Circulation problem
□ Previous dizziness