



**PHYSICAL THERAPY SERVICES OF ROCHESTER, P.C.**

540 White Spruce Boulevard, Rochester, NY 14623

(585) 427-7190 FAX: (585) 427-2287

**Vestibular History and Medical Questionnaire**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Please answer these questions to the best of your ability. Please give necessary details for **yes** answers. I realize that this form is long, but when it is filled out carefully, it allows us to devote more time to your specific problem, rather than asking you related questions during your visit. *Thank you. Jenni Tuller, MSPT*

1) Describe your problem or the reason why you are seeing me. \_\_\_\_\_

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2) Please describe in detail the circumstances and date in which the problem began and what were your initial symptoms or problems. Was there any stress around the onset of the problem? \_\_\_\_\_

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3) If you have "spells," please describe a typical spell in as much detail as possible and describe frequency and duration of them. \_\_\_\_\_

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4) Please check the symptoms which characterize your problem and grade the severity if applicable:  
0 (none), 1 (moderate), or 2 (severe).

a. Sensation of imbalance

- Trouble with walking \_\_\_\_\_
- Poor balance \_\_\_\_\_
- Falls \_\_\_\_\_

b. Sense of moving in your environment

- Spinning, tumbling \_\_\_\_\_
- Pulling sideways, forward or backward \_\_\_\_\_
- Tilting in any direction \_\_\_\_\_

c. Sensations not associated with movement

- Lightheadedness, or like you might faint \_\_\_\_\_
- Floating \_\_\_\_\_
- Swimming \_\_\_\_\_
- Giddiness \_\_\_\_\_
- Rocking \_\_\_\_\_
- Spinning inside of head \_\_\_\_\_
- Fear or avoidance of being in public places \_\_\_\_\_

d. Associated symptoms

- Sweating \_\_\_\_\_
- Nausea \_\_\_\_\_
- Vomiting \_\_\_\_\_
- Queasiness \_\_\_\_\_

e. Impaired Vision

- Double vision \_\_\_\_\_
- Blurred vision \_\_\_\_\_
- Flashes of light \_\_\_\_\_
- Jumping of vision when walking or riding in a car

**5) To what extent is your dizziness or imbalance brought on by:**

<b>(Check one answer for each question)</b>	<b>None</b>	<b>Some</b>	<b>Severely</b>
Turning over in bed, bending over or looking up			
Standing up			
Rapid head movements			
Walking on uneven surfaces			
Walking in a dark room			
Loud noises			
Cough, sneeze, strain, laugh, blowing up balloons			
Movement of objects in environment			
Moving your eyes when your head is still			
Wide open spaces			
Tunnels, bridges, supermarkets			
Menstrual periods (if applicable)			

**6) Other questions concerning your dizziness:**

**Yes**

**No**

Can you bring on your dizziness voluntarily? If yes, please describe below.		
Do/did you have moderate to severe motion sickness? If yes, when did it start?		
Do/did you avoid situations in which you were tumbled or spun? (amusement rides, merry-go-rounds) When did that begin?		
Has anyone ever observed jerking of your eyes with dizzy spells?		

**7) Have you ever had: (If yes, please describe below)**

**Yes**

**No**

Repeated or frequent ear infections		
Difficulty hearing		
Pain, fullness, or pressure in your ear		
Pain, pins/needles, numbness, twitching, or weakness of face		
Crossed eyes/lazy eye		
Ringing in ear (tinnitus) If yes, please answer following questions:		
Frequency/duration of ringing over last 6 months _____		
Please check the correct answers: The ringing is primarily in the <input type="checkbox"/> right, <input type="checkbox"/> left, <input type="checkbox"/> both ears. The ringing is <input type="checkbox"/> steady, <input type="checkbox"/> pulsating, <input type="checkbox"/> high or <input type="checkbox"/> low pitched.		

**8) REVIEW OF SYSTEMS (If yes, please describe below)**

Within the last 6 months have you noted:

Yes

No

	Yes	No
Significant loss in strength		
Significant loss of energy		
10 pound or more weight change (If yes, <input type="checkbox"/> up or <input type="checkbox"/> down?)		
Significant memory loss (amnesia)		
Significant change in hand writing		
Pins and needles, numbness in arms or legs		
Muscle or joint aches (If yes, which_____)		
Urinary Incontinence		
Problems with sleeping		
Shortness of breath		
Trouble chewing_____, swallowing _____, or speaking		
Incoordination		
Palpations (irregular or fast/slow beatings) of the heart		
Headaches (If yes, please answer the following questions):		
Age of onset of headaches _____ years old		
Number of headaches per month _____ Average pain intensity (0-10) _____		
Since the onset of headaches, have you had at least 5 headaches that:		
Lasted 4 hours or more?		
Started on one side of the head? If yes, which side? <input type="checkbox"/> Left <input type="checkbox"/> Right		
Were throbbing or pulsing in quality?		
Were severe enough to interfere with your schedule?		
Were aggravated by routine physical activity?		
Were associated with nausea or vomiting?		
Were aggravated by bright lights or loud noise?		

**8) PAST MEDICAL HISTORY**

Have you had any injuries due to trauma? Yes No

If yes, please describe injury and when it occurred: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you had or been exposed to any of the following?

Yes

No

	Yes	No
Loud noises (guns, machinery, loud music)		
Drug therapy for cancer		
Meningitis		
Other infections		

Has your past or present health been affected by:

Yes

No

Heart problems		
Diabetes		
Thyroid disorders		
Treatment by a psychiatrist/ for <input type="checkbox"/> depression, <input type="checkbox"/> anxiety, <input type="checkbox"/> severe stress?		
High cholesterol		
<input type="checkbox"/> High or <input type="checkbox"/> low blood pressure		
Pain in back of jaw (TMJ), grinding		
Loss of consciousness (fainting)		
Seizures or convulsions		
Arthritis		
Neck pain		

**9) FAMILY HISTORY**

Have your immediate family members had/have:

Yes

No

Who?

Headaches			
Meniere's Syndrome			
Hearing loss			
Vertigo or dizziness			
Balance problems or tremor			
Diabetes			
Cancer or brain tumors			
Stroke			
Heart disease			
High Blood Pressure (hypertension)			
Very Low Blood Pressure (hypotension)			
Other Neurologic disorders			

**11) THIS EPISODE HAVE YOU HAD:**

Yes/No

When?

Result?

Hearing test			
Evaluation by neurologist			
Evaluation by an ear doctor			
Evaluation by an eye doctor			
Caloric test (water or air in ear)			
MRI ( <input type="checkbox"/> with dye contrast, <input type="checkbox"/> without dye contrast)			

## 12) DIZZINESS SCALE: Part 1

**Instructions:** Please answer the following questions about your dizziness and how it affects your life. Read each question and the circle a number on the scale under that question to indicate how that question applies to you.

In the last 6 months, what percentage of the time has dizziness interfered with your activities?

0%    10%    20%    30%    40%    50%    60%    70%    80%    90%    100%

a. Rate the level of your dizziness at this moment.

1	2	3	4	5
not at all	slightly	moderately	quite a bit	extremely

b. Since the time your dizziness began, how much has your dizziness changed your ability to work?

1	2	3	4	5
not at all	slightly	moderately	quite a bit	extremely

c. How much has your dizziness changed your ability to do household chores?

1	2	3	4	5
not at all	slightly	moderately	quite a bit	extremely

d. Does your dizziness significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing or to parties?

1	2	3	4	5
not at all	slightly	moderately	quite a bit	extremely

e. To what extent does dizziness prevent you from driving your car?

1	2	3	4	5
not at all	slightly	moderately	quite a bit	extremely

## DIZZINESS SCALE: Part 2

This scale consists of a number of words that describe different feelings and emotions. Read each item and then mark the appropriate answer in the space next to the word. Indicate to what extent you generally feel this way (on average). Use the following scale to record your answers.

1	2	3	4	5
not at all	slightly	moderately	quite a bit	extremely

\_\_\_ interested

\_\_\_ irritable

\_\_\_ jittery

\_\_\_ distressed

\_\_\_ alert

\_\_\_ active

\_\_\_ excited

\_\_\_ ashamed

\_\_\_ afraid

\_\_\_ upset

\_\_\_ inspired

\_\_\_ hostile

\_\_\_ strong

\_\_\_ nervous

\_\_\_ enthusiastic

\_\_\_ guilty

\_\_\_ determined

\_\_\_ proud

\_\_\_ scared

\_\_\_ attentive

Thank you for taking the time to fill out this form. If you have any need to change or cancel your appointment, please call the office at (585) 427-7190 as soon as possible.