PHYSICAL THERAPY SERVICES of ROCHESTER

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 for your time.*

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

_____

_____

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? _____

_____

_____

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

_____

_____

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:

(Check one answer for each question)	None	Some	Severely
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 every observed jerking of your eyes with dizzy spells?		

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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 ☐right, ☐left, ☐both ears. The ringing is ☐steady, ☐pulsating, ☐high or ☐low pitched.		

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

Within the last 6 months have you noted:	**Yes**	**No**
Significant loss in strength		
Significant loss of energy		
10 pound or more weight change (If yes, ☐up or ☐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? ☐Left ☐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?		

9) 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
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 ☐depression, ☐anxiety, ☐severe stress?		
High cholesterol		
☐High or ☐low blood pressure		
Pain in back of jaw (TMJ), grinding		
Loss of consciousness (fainting)		
Seizures or convulsions		
Arthritis		
Neck pain		

10) 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:	**Y/N**	**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 (☐with dye contrast, ☐without dye contrast)			

The Dizziness Handicap Inventory (DHI)

P1. Does looking up increase your problem?	○ Yes ○ Sometimes ○ No
E2. Because of your problem, do you feel frustrated?	○ Yes ○ Sometimes ○ No
F3. Because of your problem, do you restrict your travel for business or recreation?	○ Yes ○ Sometimes ○ No
P4. Does walking down the aisle of the supermarket increase your problems?	○ Yes ○ Sometimes ○ No
F5. Because of your problem, do you have difficulty getting into or out of bed?	○ Yes ○ Sometimes ○ No
F6. Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to the movies, dancing, or going to parties?	○ Yes ○ Sometimes ○ No
F7. Because of your problem, do you have difficulty reading?	○ Yes ○ Sometimes ○ No
P8. Does performing more ambitious activities such as sports, dancing, household chores (sweeping or putting dishes away) increase your problems?	○ Yes ○ Sometimes ○ No
E9. Because of your problem, are you afraid to leave your home without having someone accompany you?	○ Yes ○ Sometimes ○ No
E10. Because of your problem, have you been embarrassed in front of others?	○ Yes ○ Sometimes ○ No
P11. Do quick movements of your head increase your problem?	○ Yes ○ Sometimes ○ No
F12. Because of your problem, do you avoid heights?	○ Yes ○ Sometimes ○ No
P13. Does turning over in bed increase your problem?	○ Yes ○ Sometimes ○ No
F14. Because of your problem, is it difficult for you to do strenuous homework or yard work?	○ Yes ○ Sometimes ○ No
E15. Because of your problem, are you afraid people may think you are intoxicated?	○ Yes ○ Sometimes ○ No

F16. Because of your problem, is it difficult for you to go for a walk by yourself?	○ Yes ○ Sometimes ○ No
P17. Does walking down a sidewalk increase your problem?	○ Yes ○ Sometimes ○ No
E18. Because of your problem, is it difficult for you to concentrate?	○ Yes ○ Sometimes ○ No
F19. Because of your problem, is it difficult for you to walk around your house in the dark?	○ Yes ○ Sometimes ○ No
E20. Because of your problem, are you afraid to stay home alone?	○ Yes ○ Sometimes ○ No
E21. Because of your problem, do you feel handicapped?	○ Yes ○ Sometimes ○ No
E22. Has the problem placed stress on your relationships with members of your family or friends?	○ Yes ○ Sometimes ○ No
E23. Because of your problem, are you depressed?	○ Yes ○ Sometimes ○ No
F24. Does your problem interfere with your job or household responsibilities?	○ Yes ○ Sometimes ○ No
P25. Does bending over increase your problem?	○ Yes ○ Sometimes ○ No

DHI Scoring Instructions

The patient is asked to answer each question as it pertains to dizziness or unsteadiness problems, specifically considering their condition during the last month. Questions are designed to incorporate functional (F), physical (P), and emotional (E) impacts on disability.

To each item, the following scores can be assigned:

No=0 Sometimes= 2 Yes=4

Scores: Scores greater than 10 points should be referred to balance specialists for further evaluation

16-34 Points (mild handicap) 54+ Points (severe handicap)

36-52 Points (moderate handicap)