

Chesapeake Hearing Centers Dizziness/Imbalance History Form

I. Chief Concern

Please check all the symptoms you are currently experiencing below:

- Dizziness
- Lightheadedness
- Vertigo (spinning)
- Blacking out or fainting
- Imbalance
- Unsteadiness
- Falling
- Sudden "drop attacks"

Describe in your own words how your imbalance or dizziness feels:

II. HISTORY OF PRESENT ILLNESS

1. When did your problem start? (Date) _____
2. Was there any related event? _____ If yes, what? _____
3. Was the onset of your problem: Gradual Sudden Overnight Other _____
4. Is the problem currently: Getting better Same Getting worse
5. Is your dizziness/imbalance: Constant Comes and goes
If it comes and goes:
Episodes occur every: ___ hours ___ days ___ weeks ___ months
Episodes last: ___ seconds ___ minutes ___ hours ___ days ___ months
6. Does your dizziness/imbalance occur with position changes: Yes No
7. Do you know of anything that makes your dizziness worse?

-
8. Have you ever fallen due to your problem? Yes No
 9. Do you have a history of Migraines? Yes No
 10. Have you ever had IV antibiotics or chemotherapy? Yes No

III. HEARING HEALTH

1. Do you have hearing loss? Yes No
2. Has your hearing changed since this problem started? Yes No
3. Do you have fullness or pressure in your ear? Yes No
4. Do you have a history of ear surgery or ear trauma? Yes No

IV. OTHER

1. Have you seen any other healthcare provider for this problem? Yes No
Who? _____

2. Have you had tests done for this problem elsewhere?
 - ENG/VNG Where: _____ When: _____ Results: _____
 - MRI/CT Where: _____ When: _____ Results: _____
 - Hearing test Where: _____ When: _____ Results: _____
 - Other Where: _____ When: _____ Results: _____

Medical Problem/Disease	Medication	When did this begin?

Anything else you feel your audiologist should know.
