Oregon Ear, Nose and Throat Center Vestibular Case History Form

Name: _____ DOB: _____ Date: _____

1. How would you describe your symptoms? Check all that apply.
   - ☐ Spinning (Check all that apply)
     - ☐ As if things are moving around me OR ☐ As if I am spinning
   - ☐ Imbalance
   - ☐ Lightheadedness
   - ☐ Fainting or blacking out (or feeling like you are about to faint)
   - ☐ Feeling disoriented
   - ☐ Falling or tendency to fall
   - ☐ Other: _____

2. Any family history of dizziness or balance problems? Yes No

3. Frequency of symptoms (Check all that apply): ☐ Constant ☐ Intermittent
   - If not constant, how often do you notice your symptoms? _____
   - When symptoms occur, how long do they last? _____

4. When did you first notice your symptoms? _____
   - The onset of symptoms was (Check the most appropriate): ☐ Sudden ☐ Gradual
   - Describe: _____
   - Were you sick or had flu-like symptoms at the time? _____
   - Any major life events around that time? _____
   - Any physical injuries around symptom onset? _____
   - Any change in medication around that time? _____
   - Any dizziness/balance concerns before these symptoms began? _____

5. Describe anything that makes your symptoms better: _____
   _____

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6. Do any of the following bring on or make your symptoms **worse**? Please check all that apply and describe if applicable.

☐ Rolling over in bed: right or left	☐ Loud noises or bright lights
☐ Looking up/down/right/left	☐ Coughing or sneezing
☐ Bending over	☐ Pressure or elevation changes
☐ Standing up too fast	☐ Complex patterns (ex. Aisle at grocery store, moving cars, patterned carpet)
☐ Quick head or body movement(s)	☐ Stress or anxiety
☐ Changing body position(s)	☐ Menstrual cycle
☐ Exercise or physical exertion	☐ Other:

7. When your symptoms are present and active, do you notice any of the following? Please check all that apply and describe if applicable.

☐ Reduced hearing	☐ Difficulty concentrating
☐ Ringing, buzzing, or humming in your ears (tinnitus)	☐ Headaches/migraines
☐ Pressure in ears and/or head	☐ Sensitivity to light, sound or smell
☐ Double vision, blurred vision, or blindness	☐ Difficulty walking in the dark or on uneven surfaces
☐ Visual disturbances (spots, colors, lights, etc.)	☐ Nausea or Vomiting
☐ Numbness or weakness	☐ Panic attacks
☐ Difficulty swallowing	☐ Anxiety
☐ Loss of consciousness	☐ Hot/cold sweats
☐ Fainting	☐ Heart rate increase or decrease
☐ Slurred speech	☐ Other:

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8. Have you fallen as a result of your symptoms? Yes No

   If yes, how many times? _____

9. Do you have any of the following medical conditions? Please check all that apply:

☐ Allergies	☐ Head, neck or brain injuries
☐ Anemia	☐ Headaches/migraines
☐ Anxiety	☐ High blood pressure
☐ Arthritis	☐ History of ear surgeries
☐ Autoimmune disorder	☐ Memory loss
☐ Cancer (current or past)	☐ Motion sickness
☐ Cataracts or other eye-related conditions	☐ Neurological conditions
☐ Cardiovascular disease	☐ Sensitivity to light, sound and/or smell
☐ Depression	☐ Stroke
☐ Diabetes	☐ Other: _____

11. Please list any previous or current substance use including marijuana, alcohol or illicit drugs?

12. Please list the medications and/or drugs that you have consumed within the last 48 hours:

13. Please list any physical restrictions you may have (ex. Neck stiffness, back pain, etc):

14. Have you ever seen a physical therapist, occupational therapist, neurologist, or cardiologist for your symptoms? If so, please list (name, place, and when first seen)