ATHENS PHYSICAL THERAPY
ATHENS NEURO AND BALANCE REHABILITATION
PHYSICIANS BACK AND NECK CLINIC
BETTER BONE CLINIC
CHRISTOPHER E. DOERR, D.O., P. C.

VESTIBULAR MEDICAL HISTORY

Patient Name_____Date of Birth_____

Appointment Date_____ Reason for this visit_____

_____Date Problem began_____

CHECK ALL THAT APPLY:

□ Acoustic Neuroma	□ Asthma	□ Blurred Vision
□ Brain Tumor	□ Car Sickness	□ Cataracts
□ COPD	□ Depression	□ Dizziness
□ Double Vision	□ Ear discharge or pain	□ Emphysema
□ Eye Disease	□ Fainting	□ Glaucoma
□ Headaches-Migraine	□ Headache-Other	□ Hearing Aides
□ Hearing Loss	□ High Blood Pressure	□ Low Blood Pressure
□ Memory Loss	□ Meniere's Disease	□ Nausea or Vomiting
□ Nervous Problem	□ Numbness or tingling in hands or feet	□ Pregnant currently
□ Pressure/Fullness in ears	□ Respiratory disease	□ Ringing/sounds in ears
□ Ruptured ear drum	□ Seizures	□ Shortness of breath
□ Sinus problems	□ Sleep Apnea	□ Stroke
□ Traumatic Brain injury (knocked unconscious)	□ Vertigo	□ Wear glasses

CHECK ANY SYMPTOMS THAT ARE PART OF YOUR DIZZINESS OR BALANCE PROBLEMS:

□ Lightheadedness	□ Fainting/loss of consciousness
□ You are spinning inside	□ Feeling detached from your body
□ Unsteady when walking	□ Headache
□ Falling	□ Seeing stationary things move when you are still
□ Slow heart rate	□ Seeing stationary things move when you are moving
□ Fast heart rate	□ Panic feelings
□ Nausea/Vomiting	□ Objects spinning about you
□ Change in vision during attacks	□ Other

HOW FREQUENTLY DO YOU HAVE THESE ATTACKS?

□ All the time	□ every other week	□ Every day
□ One a month	□ 3 times a week	□ 1 time a week
□ Other, please describe		

Patient Name_____ Date of Birth_____

HOW LONG DO YOUR ATTACKS LAST?

☐ 1 Minute or less	☐ 5 Minutes or less	☐ 10 minutes or less
☐ 30 minutes or less	☐ 30-60 minutes	☐ 2-3 hours
☐ Full day	☐ 2-3 days	☐ 1 week
☐ Other		

DID YOUR PROBLEM START SUDDENLY OR SLOWLY?_____

HAVE YOU HAD SIMILAR SYMPTOMS IN THE PAST? _____

HOW INTENSE ARE YOUR SYMPTOMS?_____

WHAT ACTIVITIES OR POSITIONS START YOUR SYMPTOMS OR MAKE THEM WORSE? CHECK ALL THAT APPLY

☐ Lying down from sitting	☐ Looking up or down
☐ Sitting up from lying down	☐ Turning head right or left
☐ Rolling right or left in bed	☐ Walking down a store aisle
☐ Standing up from sitting	☐ Riding and elevator or escalator
☐ Bending over	☐ Watching traffic
☐ Straightening up from bending	☐ Reading
☐ Walking	☐ Using a computer
☐ Riding in the car	☐ Other

LIST ANY MEDICATIONS YOU ARE TAKING FOR YOUR VERTIGO/DIZZINESS PROBLEMS_____

_____

DID YOU START ANY NEW MEDICATIONS RECENTLY? _____

HAVE YOUR SYMPTOMS CHANGED IN THE LAST 6 WEEKS? ☐ BETTER ☐ WORSE ☐ NO CHANGE

IS THE PROBLEM PREVENTING YOU FROM:

☐ WORKING ☐ WALKING ☐ HOUSEWORK ☐ HOBBIES ☐ OTHER

***My signature below confirms that the information provided on this document is accurate to the best of my knowledge*.**

Patient Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

Revised 9/2016