Vestibular Form / For the "Dizzy" Patient

Patient Name:_________________________________Date:_________________

<u>Answer each question as to how it relates to your dizziness or unsteadiness</u>

1. Does looking up increase your problems? (Y / N / Sometimes)
2. Does your problem make you feel frustrated? (Y / N / Sometimes)
3. Does your problem make you restrict travel? (Y / N / Sometimes)
4. Does walking down the aisle of a supermarket increase your symptoms or your problems? (Y / N / Sometimes)
5. Do you have difficulty getting into bed? (Y / N / Sometimes)
6. Do you have restrictions in social activity? (Y / N / Sometimes)
7. Do you have difficulty reading? (Y / N / Sometimes)
8. Does it embarrass you in front of others? (Y / N / Sometimes)
9. Do quick head movements increase your problems? (Y / N / Sometimes)
10. Do you avoid heights? (Y / N / Sometimes)
11. Does turning over in bed increase your symptoms (Y / N / Sometimes)
12. Is it difficult to do strenuous work? (Y / N / Sometimes)
13. Do you avoid driving your car in the daytime? (Y / N / Sometimes)
14. Are you afraid that people think you are intoxicated? (Y / N / Sometimes)
15. Is it difficult for you to go on a walk by yourself? (Y / N / Sometimes)
16. Does walking down a sidewalk increase your problem? (Y / N / Sometimes)
17. Is it difficult for you to concentrate? (Y / N / Sometimes)
18. Are you afraid to stay at home alone? (Y / N / Sometimes)
19. Do you feel handicapped? (Y / N / Sometimes)
20. Do you avoid driving your car in the dark? (Y / N / Sometimes)
21. Are you depressed? (Y / N / Sometimes)
22. Do you have family or relationship stress? (Y / N / Sometimes)

Do you have spells of vertigo (A sense of spinning)?
If yes, how long do the spells last?_______________________________________
When was the last time it occurred?_______________________________________
Do you feel as if you are spinning or the world is spinning____________________
Is your vertigo

_____Spontaneous
_____Induced by motion
_____Induced by position changes

Do you have feelings of being off balance (Disequilibrium)? (Y / N)
Is your feelings of being off balance

_____Constant
_____Spontaneous
_____Induced by motion
_____Worse with fatigue
_____Worse outside
_____Induced by position changes
_____Worse in the dark
_____Worse on uneven surfaces
_____Worse when laying
_____Worse when sitting
_____Worse with walking
_____Worse with standing

Have you actually fallen to the ground from your problem (Y / N)
If yes, please describe:____

How often do you fall?____
Have you injured yourself from falling? (Y / N)
Do you stumble, stagger or side step when walking? (Y / N)
Do you drift to one side when you walk? (Y / N)
If yes, which side do you drift to _____Right / _____Left

Are you independent in self care activities? (Y / N)
Can you drive? (Y / N)
In the daytime? (Y / N) In the nighttime? (Y / N)
Do you have hearing problems? (Y / N)
Do you have ringing in your ears? (Y / N)
Do you have vision problems (Y / N)
Are you working? (Y / N)
Are you on medical disability? (Y / N)

Please write down any thing else you would like to state about your current problems as it relates to your vertigo or lack of balance and stability.____

Doctors Notes:

Patient Signature:____**Date:**__________

Doctor Signature:____**Date:**__________

Interpreter Signatue:____**Date:**__________