VNG Patient History

Please spend a few moments to answer the following questions to your best of your ability regarding your dizziness, vertigo, imbalance, or unsteadiness.

Name: ____ Date of birth: _____________________
Referred by: ____
Emergency contact name/relationship: ____
Emergency contact telephone number: ____
When did your problem first occur? _____________________ How long did it last? _________________

Please circle Yes or No to the following sensations you have experienced.

Yes No Do you experience motion/sea/air sickness?
Yes No Did you experience motion sickness as a child?
Yes No Do you have a family history of motion sickness? Who? _____________
Yes No Do you experience migraine headaches?
Yes No Did you have any injuries to your head? When? ___________________
Yes No If you received a head injury, were you unconscious?
Yes No Have you ever had a neck injury?
Yes No Have you ever fallen? How often? _______________________________
Where? (i.e. inside home, outside home, work)____________________
Yes No Are you afraid of falling?
Yes No Do you take any medications regularly? What: _____________________
____
Yes No Do you use alcohol?

If you have dizziness, please circle either Yes or No and fill in the blanks to your best ability. If you do not experience dizziness, please go to the next section.

Yes No My dizziness is constant.
How often is an episode of dizziness? ____________________________
Yes No Do you have any warning that the episode is about to start?
Yes No Is the dizziness provoked by head/body movements?
If so, which direction?____
Yes No Is the dizziness better or worse at a particular time of day?
If so, when? ____
Yes No Do you know of anything that will stop your dizziness or make it better?
What? ____

Do you experience any of the following sensations? Please circle or fill in the blanks if needed.

Yes	No	Light headedness
Yes	No	Blacking out of loss of consciousness
Yes	No	Sensation of object /room are spinning or turning around
Yes	No	Sensation that you are turning or spinning
Yes	No	Tendency to fall? To the right or left? ____________________________
		Forward or backward? __________________________
Yes	No	Loss of balance when walking? Veer to the right or left?_____________
Yes	No	Do you have trouble walking in the dark?
Yes	No	Do you have problems turning to one side or another?
Yes	No	Nausea or vomiting
Yes	No	Pressure in head

Have you experienced any of the following symptoms?

Yes	No	Double vision
Yes	No	Blurred vision or blindness
Yes	No	Spots before your eyes
Yes	No	Numbness of face, arms, or legs
Yes	No	Weakness in arms or legs
Yes	No	Difficulty swallowing
Yes	No	Tingling around the mouth
Yes	No	Difficulty speaking

If you have not had a recent hearing test at our office, please answer the following questions.

Yes	No	Do you have a difficult time hearing?
		Do you have a better hearing ear?_____________________________
Yes	No	Does your hearing change with your symptoms? How?_______________
		____
Yes	No	Do you experience any tinnitus? (i.e., ringing, humming, chirping)
Yes	No	Is it constant?
Yes	No	Is it in both ears? If not, which ear?________________________
Yes	No	Punctured ear drum (Which ear? ________________)
Yes	No	Ear pain
Yes	No	Ear drainage
Yes	No	Ear infections
Yes	No	Wax issues