Vestibular Test

Name: ______________________ Date: ______________

Date of Birth: ______________ Age: ________ Contact number: ______________

Please describe the specifics of your problem to the best of your ability:

Symptoms & Causes

Please describe your first episode of dizziness/vertigo:

Date: ______________ Time: ______________

What were you doing?

Please check (✓) the ones which apply to you:

- ☐ You feel off balance
- ☐ You feel lightheaded
- ☐ You have a sensation of falling (Direction: ______________)
- ☐ You veer to a side when walking (Direction: ______________)
- ☐ You experience blurring or double vision
- ☐ You have fallen due to your dizziness
- ☐ You experience loss of hearing (Which ear: ______________)
- ☐ Your hearing fluctuates after dizzy spells
- ☐ You experience tinnitus (high pitch noise in your ear/s) (Which ear: ______________)
- ☐ You experience pressure or fullness in your ear (Which ear: ______________)
- ☐ You feel numbness or tingling in or around your ear (Which ear: ______________)
- ☐ Others: ______________

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Which of the following symptoms was the first?

____

How long do they last?

____

Have you had more than one episode of dizziness? ☐ *Yes ☐ No

*If yes, proceed with the following questions: ______________________________

Has it increased or decreased in frequency? ☐ *Yes ☐ No ☐ Other

Further Explanation: ______________________________

Has it increased in intensity? ☐ *Yes ☐ No ☐ Other

Further Explanation: ______________________________

Is your dizziness followed by nausea or vomiting? ☐ *Yes ☐ No

When was the last time? ______________________________

How often does it happen: ______________________________

Please check what you think may be related to your dizziness or cause your dizziness:

- ☐ Nausea/vomiting
- ☐ Menstruation (Date of last period: ______________)
- ☐ Loud noises (Noise: ______________)
- ☐ Walking Location (Location: ______________)
- ☐ Change in Body Position (Position: ______________)
- ☐ Time of Day (What time: ______________)
- ☐ Change in Diet (Changes: ______________)
- ☐ *Lifestyle

***If you checked lifestyle, please answer the following questions:**

Do you currently smoke? ☐ *Yes ☐ No

How many and how often? ______________________________

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Did you smoke in the past? ☐ *Yes ☐ No

Quitting Date: ______________________________

Do you drink alcohol? ☐ *Yes ☐ No

How many & how often: ______________________________

Do you drink caffeinated beverages? ☐ *Yes ☐ No

What do you drink & how much do you consume daily: ______________________________

Personal and Family Medical History

Please list ALL your current medications and the following: medication name, dosage, frequency, and date started.

Medications	Dosage	Frequency	Estimated Start Date

Do you have any medication allergies? ☐ *Yes ☐ No

If yes, what are they: ______________________________

Please list ALL your current treatment plans, if any, and what they're for.

Treatment Plan	Diagnosis

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Please list ALL ear-related concerns you've experienced/are experiencing (e.g., ear pain, ear operations, ear infections).

Please list ALL vestibular system concerns that run in the family (e.g., Meniere's Disease, vertigo, hearing loss, neurological disease)

Concerns	Relationship with the Patient

Please list ALL vestibular tests, neurological exams, or physical examinations you've undergone, date, location, and results:

Test/Exam	Date	Location	Results

Patient's Signature: ______________________________

Date: ______________________________

Reviewed by: ______________________________

Date: ______________________________