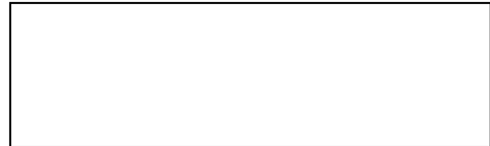

UCSF Medical Center

AUDIOLOGY **VESTIBULAR HISTORY**

Name: ______________________ **Date of Birth:** ______________ **Age:** ________

Today's Date:______________________ **Phone number:** ______________________

Referring MD: ____________________ **Next MD Appt:** ______________________

Please answer these questions to the best of your ability:

Briefly describe your problem:

____

____

____

____

Describe your first episode of dizziness or vertigo:

Date of onset: ______________________ Time of day: ______________________

What were you doing when it began? ______________________________

What were the first symptoms? ______________________________

How long did these symptoms last?

___ Seconds ___ Minutes ___ Hours ___ Days _ Constant

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

If yes, how often do these episodes occur? ______________________________

If no, skip to Page 2

Since the first episode, are they becoming more or less frequent or no change?

___ More frequent ___ Less frequent ___ No Change ___ N/A

Since the first episode, are they becoming more or less severe or no change?

___ More severe ___ Less severe ___ No Change ___ N/A

How long do these symptoms last?

___ Seconds ___ Minutes ___ Hours ___ Days ___ Constant __________

Have you experienced nausea or vomiting? ___ Yes ___ No

If yes, how often? ______________________________

If yes, do you think it is related to your dizziness?____ Yes ___ No

Does anything make your symptoms worse? ___ Yes ___ No

If yes, what? ______________________________

Does anything make your symptoms better?___ Yes ___ No

If yes, what? ______________________________

When was your last episode of dizziness? ______________________

Do loud noises cause your dizziness? ___ Yes ___ No

Do you think your dizziness is related to your menstrual cycle? ___ Yes ___ No ___ N/A

The following information will help us understand your symptoms. Please check those items that describe your symptoms.

___ You are off balance
___ You are lightheaded
___ You have a sensation of falling (right/left)
___ Changes in body position increase the dizziness Which positions? ______________________
___ You veer to the (right/left) when walking
___ Walking in the dark increases your dizziness
___ Walking in shopping malls increases your dizziness
___ You experience blurring or double vision
___ Your dizziness has caused you to fall

Ear and Hearing History

Do you think you have any loss of hearing?		___ Yes	__ No
If yes, which ear?	_____ Right	___ Left	__ Both
Does your hearing fluctuate with dizzy episodes?		___ Yes	__ No
Do you experience tinnitus (noise in your ear(s))?		___ Yes	__ No
If yes, which ear?	_____ Right	___ Left	__ Both
Do you experience pressure/fullness in your ear(s)?		___ Yes	__ No
Do you ever feel numbness or tingling in or around your ear?		___ Yes	__ No
If yes, which ear?	_____ Right	___ Left	__ Both
Have you experienced loud noise exposure in the past?		___ Yes	__ No
Have you ever had any ear infections, earaches or ear pain?		___ Yes	__ No
If yes, which ear?	_____ Right	___ Left	__ Both
Do you have a hole in your eardrum?		___ Yes	__ No
If yes, which ear?	_____ Right	___ Left	__ Both
Have you had any ear operations?		___ Yes	__ No

If yes, please describe: ____

Lifestyle Questions

Do you drink alcohol? ___ Yes __ No
If yes, how many drinks per day? ____________________________
Do you smoke? ___ Yes __ No
If yes, how many cigarettes per day? ____________________________
If no, have you smoked in the past? ___ Yes __ No
When did you quit? ____________________________
Do you consume caffeinated beverages? ___ Yes __ No
If yes, on average how many cups of caffeinated beverages do you consume per day? ______________
Do you exercise? ___ Yes __ No
If yes, how many times a week and for how long? ____________________________

Medications

Please list all your current medications, including hormones, birth control pills, vitamins, etc. Please include the name of the medication, dosage and times per day taken (attach additional sheets if necessary):

Medication	Dosage	#Times per day	Taken in the past 48 hours?
			Yes/No
			Yes/No
			Yes/No
			Yes/No

What medications have you taken specifically for your dizziness?

Medication	Dosage	#Times per day	Taken in the past 48 hours?
			Yes/No
			Yes/No
			Yes/No
			Yes/No

List any medication allergies:

____

____

Past Medical History

Please check those items you have experienced and date of any treatment:

		Treatment Date			Treatment Date
___	Low back pain	________	___	Loss of vision	________
___	Neck pain	________	___	HIV/AIDS	________
___	Foot problems	________	___	Irregular heartbeat	________
___	Loss of feeling in feet	________	___	Heart attack	________
___	Ankle sprain/fracture	________	___	Cardiac surgery	________
___	Neck injury	________	___	TMJ	________
___	Whiplash	________	___	Jaw pain	________
___	Knee/Hip injury	________	___	Recent dental work	________
___	Mononucleosis	________	___	Arthritis	________
___	Concussion	________	___	Stroke	________
___	Head injury	________	___	Seizure	________
___	Loss of consciousness	________	___	Convulsion	________
___	Headaches	________	___	Depression	________
___	Migraines	________	___	Unusual stress	________
___	Diabetes	________	___	Panic attacks	________
___	Low blood sugar	________	___	Treatment by psychiatrist	________
___	High cholesterol	________	___	Treatment by psychologist	________
___	Eye problems	________	___	Other	________

If you have any relatives with the following medical problems, please describe the relationship (parent, sibling, child, other):

___	Migraines	______________	___	Hearing loss	______________
___	Meniere's Disease	______________	___	Stroke	______________
___	Vertigo/dizziness/balance problems	______________	___	Neurological disease	______________

Previous Medical Tests

Check all that apply. Please include the date of test, where the test was performed and the results of the testing if you know them (indicate by item number):

___ 1. Hearing test
___ 2. ENG (Electronystagmography) or VNG (Videonystagmography)
___ 3. MRI of brain (Magnetic Resonance Imaging
_____ with contrast
_____ without contrast
___ 4. MRI of ears
_____ with contrast
_____ without contrast
___ 5. MRA (Magnetic Resonance Angiography)
___ 6. CT Scan of brain
___ 7. CT Scan of ears
___ 8. ABR (Auditory Brainstem Response/Brainstem Auditory Evoked Response)
___ 9. OAE (Otoacoustic Emissions)
___ 10. Balance Platform Test (Posturography)
___ 11. Rotary Chair Test
___ 12. VAT (Vestibular Autorotation Test)
___ 13. ECOG (Electrocochleography)
___ 14. EEG (Electroencephalogram)
___ 15. EKG (Electrocardiogram)
___ 16. Holter monitor testing for irregular heartbeat
___ 17. Neck X-rays
___ 18. Neurology Evaluation
___ 19. Lumbar Puncture (Spinal Fluid Study)
___ 20. Complete Physical Examination

Item Number: ______________ Test Date: ____________ Test Location: ____________________________
Test Results: ____

Item Number: ______________ Test Date: ____________ Test Location: ____________________________
Test Results: ____

Item Number: ______________ Test Date: ____________ Test Location: ____________________________
Test Results: ____

Item Number: ______________ Test Date: ____________ Test Location: ____________________________
Test Results: ____

Item Number: ______________ Test Date: ____________ Test Location: ____________________________
Test Results: ____

Item Number: ______________ Test Date: ____________ Test Location: ____________________________
Test Results: ____

Rev. 01/11