**VESTITULAR QUESTIONNAIRE / HEALTH HISTORY**

**NAME:** ____________________________  **DATE:** _______________

To insure you receive a complete and thorough evaluation, please provide us with important background information on the following form. If you do not understand the question, your therapist will assist you. Thank you.

### HISTORY OF PRESENT CONDITION

1. Reason for Referral  __________________________________________

2. Which of the following best describes your symptoms? (check all that apply)
   - □ (1) imbalance
   - □ (2) trouble walking
   - □ (3) staggering
   - □ (4) sense of leaning/tilt
   - □ (5) undulations (as if on a boat)
   - □ (6) vertigo (spinning events)
   - □ (7) sense of floating
   - □ (8) nausea/quetinesess
   - □ (9) visual confusion
   - □ (10) blurry vision
   - □ (11) jumping vision
   - □ (12) pain in ears
   - □ (13) ringing in ears
   - □ (14) hearing loss
   - □ (15) headache
   - □ (16) pain in neck
   - □ (17) lightheadedness
   - □ (18) disorientation
   - □ (19) poor concentration, memory or attention
   - □ (20) fatigue
   - □ (21) weakness (location)
   - □ (22) other __________

3. When did you first notice this episode of symptoms (Please indicate a specific date if possible)? __________

4. Was the onset of this episode gradual or sudden? (Check one) □ (1) gradual □ (2) sudden

5. Which of the following best describes the reason for your symptoms?
   - □ (1) a MVA (auto accident)
   - □ (2) a fall
   - □ (3) trauma
   - □ (4) during recreation/sports
   - □ (5) an infection
   - □ (6) after taking drugs/antibiotics
   - □ (7) aging
   - □ (8) unknown
   - □ (9) other __________

6. Since onset are your symptoms getting
   - □ (1) better  □ (2) worse  □ (3) not changing

7. Are your symptoms:
   - □ (1) constant
   - □ (2) provoked by head movement or activity
   - □ (3) spontaneous

8. Have you ever fallen?
   - □ (1) no
   - □ (2) yes-once in the last week
   - □ (3) yes-more than once this week
   - □ (4) other __________

9. What aggravates your symptoms?
   - □ (1) lying down
   - □ (2) going to/rising from sitting
   - □ (3) riding in or driving a car
   - □ (4) walking
   - □ (5) visual motion
   - □ (6) medication
   - □ (7) other ______

10. Have you ever had vestibular testing?
    - □ (1) No □ (2) Yes Results: __________________________

11. Activities you do not do because of your problem:
    ____________________________________________
    ____________________________________________

12. Since the onset of your current symptoms have you had:
    - □ (1) any difficulty with control of bowel or bladder function
    - □ (2) fever/Chills
    - □ (3) any numbness in the genital or anal area
    - □ (4) numbness
    - □ (5) any dizziness or fainting attacks
    - □ (6) weakness
    - □ (7) unexplained weight change
    - □ (8) night pain/sweats
    - □ (9) malaise (vague feeling of bodily discomfort)
    - □ (10) problems with vision/hearing
    - □ (11) none of the above

### MEDICATION

Please list any prescription medications you are currently taking (pain pills, injections and/or skin patches etc.):
________________________________________
________________________________________
________________________________________

Are you currently taking any of the following over the counter medications?
   - □ (1) aspirin □ (2) Tylenol □ (3) corticosteroids □ (4) antihistamines
   - □ (5) vitamins/mineral supplements □ (6) Advil/Motrin/ibuprofen □ (7) other __________
### PREVIOUS FUNCTIONAL LEVEL
- **Independent in all activities** (work, community, home, recreation)

### Self Care
- Independent in all self-care (bathing, toileting, dressing, etc.) activities
- Have difficulty performing self-care activities
- Need assistance with self-care activities
- Have difficulty performing household chores

### Social
- Need assistance with activities in community outside of home

### Hobbies:

### WORK HISTORY

<table>
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<tr>
<th>Occupation</th>
<th>(1) employed full time</th>
<th>(2) employed part time</th>
<th>(3) self employed</th>
<th>(4) homemaker</th>
<th>(5) student</th>
<th>(6) retired</th>
<th>(7) unemployed</th>
<th>(8) other</th>
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### Physical activities at work
- Sitting
- Standing
- Phone use
- Repetitive lifting
- Heavy lifting

### Are you currently receiving for seeking disability for this condition?  Yes  No

### If not performing your normal activities at work do you plan to RETURN to your previous activity level?  Yes  No

### LIVING SITUATION
- (1) live alone
- (2) live with family member/others
- (3) live with caregiver
- (4) home/apartment
- (5) retirement complex (SNF/ ICF)
- (6) assisted living complex
- (7) other

### Setting
- Stairs railing
- Stairs no railing
- No stairs
- Ramp
- Elevator
- Uneven ground

### GENERAL HEALTH
- How would you rate your general health?
  - Excellent
  - Good
  - Average
  - Fair
  - Poor

### Do you exercise outside of normal daily activities?
- (1) 5+days/wk
- (2) 3-4 days/wk
- (3) 1-2 days/wk
- (4) occasionally
- (5) zero

### Exercise, Sports/Recreation consisting of

### Do you drink caffeine containing beverages?
- No  Yes
- How many/much per day? _______

### Do you smoke?
- No  Yes
- Packs of cigarettes a day? _______

### What is your stress level?
- Low  Medium  High

### Are you seeing any health care providers other than the physical therapist for this current condition? (list)

### PAST MEDICAL HISTORY
- Have you ever had/been diagnosed with any of the following conditions?
  - Cancer (type)
  - Heart Problems
  - Depression
  - High blood pressure
  - Stroke
  - Lung Problems
  - Kidney Problems
  - Blood Disorders
  - Thyroid problems
  - Epilepsy/Seizures
  - Diabetes
  - Allergies
  - Multiple Sclerosis
  - Rheumatoid arthritis
  - Arthritis
  - Osteoporosis
  - Head Injury
  - Broken bone
  - Stomach problems
  - Other
  - Parkinson’s Disease
  - Circulation/vascular problems
  - Infectious Diseases (i.e. hepatitis, tuberculosis)

### Please list any recent/relevant past surgeries related to your current problem:

<table>
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<tr>
<th>SURGERY</th>
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### FAMILY HISTORY
- Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?
  - Diabetes
  - Cancer
  - Heart disease
  - Arthritis
  - High blood pressure
  - Osteoporosis
  - Stroke
  - Psychological Condition
  - Other