# Vestibular Patient Health Questionnaire

**Name: _____ Occupation _____**

**Phone: (H) (____) ____-_____** Age: _____ Height: _____ Weight: _____

Are you currently receiving any Home Health services from Medicare? (i.e. nursing care, infusion, home health aide, therapy…) □ No □ Yes…what home care agency are you using? _____

Is an **attorney** handling your case? □ Yes □ No Who? _____ Ph: _____

Are you currently out of work due to **this** problem? □ Yes □ No

**Current Problem**: What is bothering you?(please describe):_____
_____

Were they: □ Sudden □ Gradual □ Persistent □ Fluctuating
Did you feel as if the you or the room was spinning? (please circle) **Yes No**
When was the first attack?_____ How long did it last?_____
When was your last attack?_____ How long did it last?_____
What makes it worse?_____ Better?_____

What treatment have you had for this **current** problem?

Have you had **this problem** before? □ Yes □ No If yes, then when _____
Previous treatment? □ Yes □ No If yes, then what _____

**Y N** Do you have trouble hearing? (please circle) **Right Left Both**
Was it sudden or gradual?_____ When did you first notice a loss of hearing?_____

**Y N** Have you noticed a fullness/pressure/stiffness/ringing in your ears?(please circle) **Right Left Both**

**Y N** Does any change in head or body position make the dizziness worse?
Please describe_____

Specifically, what are you not able to do because of your current problem?_____
_____

Do you have any additional symptoms? Please **check** all that apply:

| | | | |
|---|---|---|---|
| □ Lightheadedness | □ Blurry vision | □ Memory loss | □ Blacking out |
| □ Headaches | □ ↓ concentration | □ "Heavy headiness" | □ "Foggy headiness" |
| □ Motion Intolerance | □ Rocking or swaying | □ Anxiety | □ Poor sleep patterns |
| □ Slurred speech | □ Difficulty driving | □ Objects jumping | □ Migraines |
| □ Nausea | □ Falling/leaning sensation | □ Numbness | □ Bothered by busy places |
| □ Fatigue | □ Clumsiness | □ Staggering | □ Depression |
| □ Spinning | □ Difficulty in word choice | □ Difficulty in dim lighting | □ Double vision |
| □ Dizziness | □ Swimming/floating sensation | | □ Weakness in arms/legs |

Have you recently participated in the following: □ turbulent flight □ scuba diving □ altitude changes
Recent problems: □ illness □ allergies □ stress □ head trauma □ vision deficits □ sinus □ hearing loss
□ ear infection □ BP medication □ infectious disease □ MRI/CT Scan □ medication for dizziness

Have you had any recent falls? _____

Are you able to drive?_____

When was your last eye exam?_____

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**Medical History:** □ Arthritis □ Asthma □ Emphysema □ HIV □ Night sweats
□ Cancer □ Dizziness □ Diabetes □ Osteoporosis □ AIDS □ Fever
□ Heart Disease □ Bronchitis □ Hypoglycemia □ Depression □ Migraine
□ Seizures/Falls □ Strokes □ Hypertension □ Other: _____
□ Unrelenting night pain □ Unexplained weight loss □ Bowel and/or bladder problems

Previous problems or surgeries: _____ Date: / /
_____ Date: / /
_____ Date: / /

Please list all medications you are currently taking: _____
_____
_____
_____

## DIZZINESS HANDICAP INVENTORY

Patient Name _____ Date _____

**INSTRUCTIONS:** Please CIRCLE the correct response:

1. I have dizziness/unsteadiness: (1) 1 per month (2) >1 but < 4 per month (3) more than one per week
2. My dizziness/unsteadiness is: (1) mild (2) moderate (3) severe

**Please read carefully:** The purpose of the scale is to identify difficulties that you may be experiencing because of your dizziness/unsteadiness. Please check off "YES", "SOMETIMES", or "NO" to each item. Answer each question as it pertains to your dizziness/unsteadiness only.

| YES | SOMETIMES | NO | | |
|---|---|---|---|---|
| _____ | _____ | _____ | P1. | Does looking up increase your problem? |
| _____ | _____ | _____ | E2. | Because of your problem, do you feel frustrated? |
| _____ | _____ | _____ | F3. | Because of your problem, do you restrict your travel for business or recreation? |
| _____ | _____ | _____ | P4. | Does walking down the aisle of a supermarket increase your problem? |
| _____ | _____ | _____ | F5. | Because of your problem, do you have difficulty getting into or out of bed? |
| _____ | _____ | _____ | F6. | Does your problem significantly restrict your participation in social activities such as going out to dinner, going to movies, dancing, or to parties? |
| _____ | _____ | _____ | F7. | Because of your problem, do you have difficulty reading? |
| _____ | _____ | _____ | P8. | Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting dishes away increase your problem? |
| _____ | _____ | _____ | E9. | Because of your problem, are you afraid to leave your home without someone accompanying you? |
| _____ | _____ | _____ | E10. | Because of your problem, have you been embarrassed in front of others? |
| _____ | _____ | _____ | P11. | Do quick movements of your head increase your problem? |
| _____ | _____ | _____ | F12. | Because of your problem, do you avoid heights? . |
| _____ | _____ | _____ | P13. | Does turning over in bed increase your problem? |
| _____ | _____ | _____ | F14. | Because of your problem, is it difficult for you to do strenuous house work or yard work? |
| _____ | _____ | _____ | E15. | Because of your problem, are you afraid people may think you are intoxicated? |
| _____ | _____ | _____ | F16. | Because of your problem, is it difficult for you to go for a walk by yourself? |
| _____ | _____ | _____ | P17. | Does walking down a sidewalk increase your problem? |
| _____ | _____ | _____ | E18. | Because of your problem, is it difficult for you to concentrate? |
| _____ | _____ | _____ | F19. | Because of your problem, is it difficult for you to walk around your house in the dark? |
| _____ | _____ | _____ | E20. | Because of your problem, are you afraid to stay home alone? |
| _____ | _____ | _____ | E21. | Because of your problem, do you feel handicapped? |
| _____ | _____ | _____ | E22. | Has your problem placed stress on your relationships with members of your family or friends? |
| _____ | _____ | _____ | E23. | Because of your problem, are you depressed? |
| _____ | _____ | _____ | F24. | Does your problem interfere with your job or household responsibilities? |
| _____ | _____ | _____ | P25. | Does bending over increase your problem? |

_____
**Examiner**

**OTHER COMMENTS:**_____