NATIONAL DIZZY AND BALANCE CENTER
● HEALTH HISTORY FORM

NOTE: COMPLETE USING BLACK INK ONLY

Name: _____ Date: _____

I. CHIEF COMPLAINT

1. What symptoms are you currently experiencing? (check all that apply)

□ Dizziness □ Imbalance □ Hearing Difficulty □ Visual Difficulty □ Headache / Migraine

□ Vertigo / Spinning □ Unsteadiness □ Ear Pain / Pressure □ Cognitive Difficulty □ Nausea / Vomiting

□ Lightheadedness □ Falling □ Ringing in Ears □ Anxiety □ Blacking out / Fainting

□ Other (please describe): _____

II. HISTORY OF PRESENT ILLNESS

1. When did your problem start? _____. Was the onset: □ Gradual or □ Sudden?

2. Was there any related event? □ Yes □ No – If yes, check all that apply:

□ Ear Infection / Cold or Flu □ Auto / Work-Related Accident □ Other (please describe below):

_____

3. Is your problem currently: □ Getting better □ Getting worse □ Staying the same or □ Variable?

4. Rate the average severity of your symptoms on a scale of 1 to 10 (10 being the worst): _____.

5. Is your problem: □ Constant or □ It comes and goes in spells / attacks that occur every:

□ ___ Hours □ ___ Days □ ___ Weeks, **and last for** □ ___ Seconds □ ___ Minutes □ ___ Hours □ __ Days

6. Does your problem occur with position changes? □ Yes □ No – If yes, check all that apply:

□ Rolling your body right and left □ Looking up or head back □ Bending over or head down

□ Going from lying to sitting □ Going from sitting to standing □ Turning head left / right

7. Does anything make your problem better? □ Yes □ No – If yes, check all that apply:

□ Limiting head movement □ Rest / Sleep □ Closing your eyes □ Other (please describe below):

_____

8. Does anything make your problem worse? □ Yes □ No – If yes, check all that apply:

□ Head movement □ Physical Activity □ Large crowds / Busy environments □ Other (please describe below):

_____

9. Does your problem involve any of the following associated symptoms? (check all that apply)

□ Numbness or tingling of hands / feet / lips □ Double / Blurred vision □ Weakness / Clumsiness in arms or legs

10. Does your problem make it difficult to walk or stand without assistance? □ Yes □ No

11. When you are walking, do you: □ Veer right □ Veer left □ Veer in both directions?

12. What medical providers have you seen for this problem? (check all that apply)

□ Primary Care □ Emergency Room □ ENT □ Neurology □ Physical Therapy □ Other: _____

13. What tests have been done for this problem? (check all that apply)

□ MRI/CT performed at _____ on _____. Results: _____.

□ Hearing Test performed at _____ on _____. Results: _____.

□ ENG/VNG performed at _____ on _____. Results: _____.

III. PAST SELF AND FAMILY HEALTH HISTORY

1. Please provide a list of serious injuries or illnesses with approximate dates: _____

_____

2. Please provide a list of surgical procedures with approximate dates: _____

_____

3. Have you ever received intravenous (IV) antibiotics? □ Yes □ No

4. Have you or your family had any of the following problems? (check all that apply)

	Self	Mother	Father
Anemia (note type)			
Anxiety			
Arrhythmia / Irregular Pulse			
Arthritis (note type)			
Auto-Immune Disorder (note type)			
Cancer / Tumors (note type)			
Depression			
Diabetes (note type)			
Epilepsy / Seizures			
Eye Disorder (cataracts / glaucoma)			
Heart Disease			
High or Low Blood Pressure			
High Cholesterol			
Kidney Disease			
Meniere's Disease			
Migraine Headaches			
Multiple Sclerosis			
Parkinson's			
Stroke or TIAs			
Thyroid Disease (note type)			

IV. CURRENT MEDICATIONS (provide a current and complete list of medications, including dosage instructions)

IV. ALLERGIES (provide a complete list of all allergies, including medications)

VI. SOCIAL HISTORY

1. Marital Status (check one): □ Single □ Married □ Divorced □ Widowed □ Other: _____

2. Occupation: _____ **Status:** □ Full time □ Part time □ Retired □ Other: _____

3. Current Living Situation: □ House □ Apartment □ Assisted Living □ Other: _____

4. Who do you live with? □ Alone □ Spouse □ Family □ Other: _____

5. What is your current level of activity? □ Vigorous □ Moderate □ Light □ Inactive

If activity level is low, what barriers do you face? (check all that apply)

□ Fear of Falling □ Lack of Energy / Stamina □ Lack of Time / Effort □ Other (please describe): _____

6. Caffeine Use: □ None □ I drink ___ beverages each day / week / month / year (circle one)

7. Alchohol Use: □ None □ I drink ___ beverages each day / week / month / year (circle one)

8. Tobacco Use: □ None □ I smoke / chew / other ___ times each day / week / month / year (circle one)

VII. REVIEW OF SYSTEMS

1. Are you <u>currently</u> experiencing any of the following symptoms? (check all that apply)

General	Yes	No
Fever / Chills / Sweats (circle)		
Weakness		
Fatique / Malaise (circle)		
Sleep Disorder		

Eyes	Yes	No
Blurring / Double Vision (circle)		
Vision Loss		
Eye Pain / Discharge (circle)		
Photophobia		

Ear, Nose & Throat	Yes	No
Ear Pain / Discharge (circle)		
Nasal Congestion		
Sore Throat		
Hoarseness		

Cardiovascular	Yes	No
Chest Pains		
Palpitations		
Syncope		
Shortness of Breath		

Respiratory	Yes	No
Cough		
Excessive Sputum		
Bloody Sputum		
Wheezing		

Gastrointestinal	Yes	No
Diarrhea		
Constipation		
Abdominal Pain		
Black or Bloody Stools (circle)		
Indigestion or Heartburn		
Difficult / Painful Swallowing (circle)		

Genitourinary	Yes	No
Difficult / Painful Urination (circle)		
Bloody Urination		
Excessive Urination		
Incontinence		

Musculoskeletal	Yes	No
Back Pain		
Joint Pain / Swelling (circle)		
Stiffness		
Muscle Cramps / Weakness (circle)		
Restless Legs		
Leg Pain / Swelling (circle)		

Dermatological	Yes	No
Rash		
Itching		
Dryness		
Suspicious Lesions		

Neurological	Yes	No
Numbness or Tingling		
Tremors		
Memory Loss		
Confusion		

Endocrine	Yes	No
Cold / Heat Intolerance (circle)		
Unusual Weight Change		
Excessive Thirst / Hunger (circle)		

Hematology	Yes	No
Abnormal Bruising		
Bleeding		
Enlarged Lymph Nodes		

NATIONAL DIZZY AND BALANCE CENTER

● DIZZINESS HANDICAP INVENTORY

NOTE: PLEASE COMPLETE USING BLACK INK

Name: _____ Date: _____

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer "Yes", "No", or "Sometimes" to each question by circling the corresponding "Y", "N", or "S". Answer each question as it pertains to your dizziness or imbalance only.

P	1.	Does looking up increase your problem?	Y S N
E	2.	Because of your problem, do you feel frustrated?	Y S N
F	3.	Because of your problem, do you restrict your travel for business and/or recreation?	Y S N
P	4.	Does walking down the aisle of a supermarket increase your problem?	Y S N
F	5.	Because of your problem, do you have difficulty getting into or out of bed?	Y S N
F	6.	Does your problem significantly restrict your participation in social activities, such as going out to dinner, movies, dancing, or parties?	Y S N
F	7.	Because of your problem, do you have difficulty reading?	Y S N
P	8.	Does performing more ambitious activities like sports, dancing, and household chores such as sweeping or putting dishes away increase your problem?	Y S N
E	9.	Because of your problem, are you afraid to leave your home without having someone accompany you?	Y S N
E	10.	Because of your problem, have you been embarrassed in front of others?	Y S N
P	11.	Do quick movements of your head increase your problem?	Y S N
F	12.	Because of your problem, do you avoid heights?	Y S N
P	13.	Does turning over in bed increase your problem?	Y S N
F	14.	Because of your problem, is it difficult for you to do strenuous house or yard work?	Y S N
E	15.	Because of your problem, are you afraid people may think you are intoxicated?	Y S N
F	16.	Because of your problem, is it difficult for you to go for a walk by yourself?	Y S N
P	17.	Does walking down a sidewalk increase your problem?	Y S N
E	18.	Because of your problem, is it difficult for you to concentrate?	Y S N
F	19.	Because of your problem, is it difficult for you to walk around your house in the dark?	Y S N
E	20.	Because of your problem, are you afraid to stay home alone?	Y S N
E	21.	Because of your problem, do you feel handicapped?	Y S N
E	22.	Has your problem placed stress on your relationships with members of your family?	Y S N
E	23.	Because of your problem, are you depressed?	Y S N
F	24.	Does your problem interfere with your job or household responsibilities?	Y S N
P	25.	Does bending over increase your problem?	Y S N

Scoring: Y = Yes (4 pts) S = Sometimes (2 pts) N = No (0 pts) Total = _____

Jacobson GP, Newman CW: The development of the Dizziness Handicap Inventory. *Arch Otolaryngol Head Neck Surg* 1990; 116: 424-427