Oregon | Neurology Associates

VESTIBULAR QUESTIONNAIRE / HEALTH HISTORY

NAME: _____ **DATE:** _____

To ensure 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/queasiness
- ❑ (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

Occupation_____

- ❒ (1) employed full time
- ❒ (2) employed part time
- ❒ (3) self employed
- ❒ (4) homemaker
- ❒ (5) student
- ❒ (6) retired
- ❒ (7) unemployed
- ❒ (8) other _____

Physical activities at work

- ❒ (1) sitting
- ❒ (2) standing
- ❒ (3) phone use
- ❒ (4) repetitive lifting
- ❒ (5) heavy lifting
- ❒ (6) computer use
- ❒ (7) heavy equipment operation
- ❒ (8) driving
- ❒ (9) other _____

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

- ❒ (1) stairs railing
- ❒ (2) stairs no railing
- ❒ (3) no stairs
- ❒ (4) ramp
- ❒ (5) elevator
- ❒ (6) uneven ground

other _____

GENERAL HEALTH

How would you rate your general health?

❒ Excellent ❒ Average ❒ Poor
❒ Good ❒ Fair

Do you exercise outside of normal daily activities?

- ❒ (1) 5+days/wk
- ❒ (2) 3-4 days/wk
- ❒ (3) 1-2days/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)_____
- ❒ Depression
- ❒ Stroke
- ❒ Kidney Problems
- ❒ Thyroid problems
- ❒ Diabetes
- ❒ Multiple Sclerosis
- ❒ Arthritis
- ❒ Head Injury
- ❒ Stomach problems
- ❒ Parkinson's Disease
- ❒ Circulation/vascular problems
- ❒ Infectious Diseases (i.e. hepatitis, tuberculosis)
- ❒ Heart Problems
- ❒ High blood pressure
- ❒ Lung Problems
- ❒ Blood Disorders
- ❒ Epilepsy/Seizures
- ❒ Allergies
- ❒ Rheumatoid arthritis
- ❒ Osteoporosis
- ❒ Broken bone
- ❒ Other _____

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

SURGERY	**DATE**

FAMILY HISTORY

Has anyone in your immediate family *(parents, brothers, sisters)* ever been treated for any of the following?

- ❒ Diabetes
- ❒ Heart disease
- ❒ High blood pressure
- ❒ Stroke
- ❒ Cancer
- ❒ Arthritis
- ❒ Osteoporosis
- ❒ Psychological Condition
- ❒ Other _____