

**ATHENS PHYSICAL THERAPY  
 ATHENS NEURO AND BALANCE REHABILITATION  
 PHYSICIANS BACK AND NECK CLINIC  
 BETTER BONE CLINIC  
 CHRISTOPHER E. DOERR, D.O., P. C.**

**VESTIBULAR MEDICAL HISTORY**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Appointment Date \_\_\_\_\_ Reason for this visit \_\_\_\_\_

\_\_\_\_\_ Date Problem began \_\_\_\_\_

**CHECK ALL THAT APPLY:**

<input type="checkbox"/> Acoustic Neuroma	<input type="checkbox"/> Asthma	<input type="checkbox"/> Blurred Vision
<input type="checkbox"/> Brain Tumor	<input type="checkbox"/> Car Sickness	<input type="checkbox"/> Cataracts
<input type="checkbox"/> COPD	<input type="checkbox"/> Depression	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Ear discharge or pain	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Eye Disease	<input type="checkbox"/> Fainting	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Headaches-Migraine	<input type="checkbox"/> Headache-Other	<input type="checkbox"/> Hearing Aides
<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Meniere's Disease	<input type="checkbox"/> Nausea or Vomiting
<input type="checkbox"/> Nervous Problem	<input type="checkbox"/> Numbness or tingling in hands or feet	<input type="checkbox"/> Pregnant currently
<input type="checkbox"/> Pressure/Fullness in ears	<input type="checkbox"/> Respiratory disease	<input type="checkbox"/> Ringing/sounds in ears
<input type="checkbox"/> Ruptured ear drum	<input type="checkbox"/> Seizures	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Stroke
<input type="checkbox"/> Traumatic Brain injury (knocked unconscious)	<input type="checkbox"/> Vertigo	<input type="checkbox"/> Wear glasses

**CHECK ANY SYMPTOMS THAT ARE PART OF YOUR DIZZINESS OR BALANCE PROBLEMS:**

<input type="checkbox"/> Lightheadedness	<input type="checkbox"/> Fainting/loss of consciousness
<input type="checkbox"/> You are spinning inside	<input type="checkbox"/> Feeling detached from your body
<input type="checkbox"/> Unsteady when walking	<input type="checkbox"/> Headache
<input type="checkbox"/> Falling	<input type="checkbox"/> Seeing stationary things move when you are still
<input type="checkbox"/> Slow heart rate	<input type="checkbox"/> Seeing stationary things move when you are moving
<input type="checkbox"/> Fast heart rate	<input type="checkbox"/> Panic feelings
<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Objects spinning about you
<input type="checkbox"/> Change in vision during attacks	<input type="checkbox"/> Other

**HOW FREQUENTLY DO YOU HAVE THESE ATTACKS?**

<input type="checkbox"/> All the time	<input type="checkbox"/> every other week	<input type="checkbox"/> Every day
<input type="checkbox"/> One a month	<input type="checkbox"/> 3 times a week	<input type="checkbox"/> 1 time a week
<input type="checkbox"/> Other, please describe		

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**HOW LONG DO YOUR ATTACKS LAST?**

<input type="checkbox"/> 1 Minute or less	<input type="checkbox"/> 5 Minutes or less	<input type="checkbox"/> 10 minutes or less
<input type="checkbox"/> 30 minutes or less	<input type="checkbox"/> 30-60 minutes	<input type="checkbox"/> 2-3 hours
<input type="checkbox"/> Full day	<input type="checkbox"/> 2-3 days	<input type="checkbox"/> 1 week
<input type="checkbox"/> Other		

DID YOUR PROBLEM START SUDDENLY OR SLOWLY? \_\_\_\_\_

HAVE YOU HAD SIMILAR SYMPTOMS IN THE PAST? \_\_\_\_\_

HOW INTENSE ARE YOUR SYMPTOMS? \_\_\_\_\_

**WHAT ACTIVITIES OR POSITIONS START YOUR SYMPTOMS OR MAKE THEM WORSE? CHECK ALL THAT APPLY**

<input type="checkbox"/> Lying down from sitting	<input type="checkbox"/> Looking up or down
<input type="checkbox"/> Sitting up from lying down	<input type="checkbox"/> Turning head right or left
<input type="checkbox"/> Rolling right or left in bed	<input type="checkbox"/> Walking down a store aisle
<input type="checkbox"/> Standing up from sitting	<input type="checkbox"/> Riding and elevator or escalator
<input type="checkbox"/> Bending over	<input type="checkbox"/> Watching traffic
<input type="checkbox"/> Straightening up from bending	<input type="checkbox"/> Reading
<input type="checkbox"/> Walking	<input type="checkbox"/> Using a computer
<input type="checkbox"/> Riding in the car	<input type="checkbox"/> Other

LIST ANY MEDICATIONS YOU ARE TAKING FOR YOUR VERTIGO/DIZZINESS PROBLEMS \_\_\_\_\_

DID YOU START ANY NEW MEDICATIONS RECENTLY? \_\_\_\_\_

HAVE YOUR SYMPTOMS CHANGED IN THE LAST 6 WEEKS?       BETTER     WORSE     NO CHANGE

IS THE PROBLEM PREVENTING YOU FROM:

WORKING       WALKING       HOUSEWORK       HOBBIES       OTHER

***My signature below confirms that the information provided on this document is accurate to the best of my knowledge.***

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_