Vestibular Form / For the "Dizzy" Patient

Patient Date

Answer each question as to how it relates to your dizziness or unsteadiness

	Yes	No	Sometimes
Does looking up increase your problems?			
Does your problem make you feel frustrated?			
Does your problem make you restrict travel?			
Does walking down the aisle of a supermarket increase your symptoms or your problems?			
Do you have difficulty getting into bed?			
Do you have restrictions in social activity?			
Do you have difficulty reading?			
Does it embarrass you in front of others?			
Do quick head movements increase your problems?			
Do you avoid heights?			
Does turning over in bed increase your symptoms			
Is it difficult to do strenuous work?			
Do you avoid driving your car in the daytime?			
Are you afraid that people think you are intoxicated?			
Is it difficult for you to go on a walk by yourself?			
Does walking down a sidewalk increase your problem?			
Is it difficult for you to concentrate?			
Are you afraid to stay at home alone?			
Do you feel handicapped?			
Do you avoid driving your car in the dark?			
Are you depressed?			
Do you have family or relationship stress?			

Do you have spells of vertigo (A sense of spinning)? ☐ Yes ☐ No

If yes, how long do the spells last? _____

When was the last time it occurred? _____

Do you feel as if you are spinning or the world is spinning? _____

How often do you fall? _____

Have you injured yourself from falling? ☐ Yes ☐ No

Do you stumble, stagger or side step when walking? ☐ Yes ☐ No

Do you drift to one side when you walk? ☐ Yes ☐ No

If yes, which side do you drift to? ☐ Right ☐ Left

Are you independent in self care activities? ☐ Yes ☐ No

Can you drive? ☐ Yes ☐ No

In the daytime? ☐ Yes ☐ No

In the nighttime? ☐ Yes ☐ No

Do you have hearing problems? ☐ Yes ☐ No

Do you have ringing in your ears? ☐ Yes ☐ No

Do you have vision problems ☐ Yes ☐ No

Are you working? ☐ Yes ☐ No

Are you on medical disability? ☐ Yes ☐ No

Please write down any thing else you would like to state about your current problems as it relates to your vertigo or lack of balance and stability._____

_____

_____

_____

_____

_____

Doctors Notes

Patient Signature:_____**Date:**_____

Doctor Signature:_____**Date:**_____

Interpreter Signature:_____**Date:**_____