Center for NEUROSCIENCES

X _____
Reviewed personally by Dr. Tourkevich

Vestibular Questionnaire

Please fax to (520) 320-2155 prior to your scheduling/appointment.

Patient Name: _____ **Referred by:** _____

DOB: _____ **Are you right handed? Yes / No** **Past/current occupation:** _____

Past or current tobacco/alcohol/illicit drug use (if the answer is no, please write it down): _____

What medical conditions do you have (circle all that apply and write in others):

High blood pressure	Autoimmune disease	Movement disorder (Parkinsonism, etc.)
High cholesterol (last LDL_____HDL____)	Migraine	Loss of consciousness, epilepsy, seizures,
Diabetes (last Hgb A1C_____)	Tumor	syncope, POTS
Atrial fibrillation (ablation, anticoagulation)	Gastric bypass	Stroke (list symptoms) _____

Other: _____

Surgeries: _____

_____

Did you have (circle all that apply): MRI/CT brain or spine, CT temporal bone, MRA/CTA head/neck, PET, Audiogram, EEG

Your dizziness was evaluated by (circle all that apply): otolaryngologist, cardiologist, neurologist, ophthalmologist, neuro-ophthalmologist, or vestibular physical therapist (provide their diagnoses)_____

_____

Are you currently using medicine to treat dizziness? _____**Does it help?** _____

When did you first notice dizziness and/or imbalance? _____

Was the onset relatively abrupt (seconds-hours) or gradual (days-weeks)? _____

Please describe how the symptoms progressed _____

_____

_____

_____

_____

_____

_____

Circle the symptom(s) that you have experienced:

Imbalance	Spinning
Disequilibrium	Rocking/swaying
Motion of the body, environment	Lightheadedness/faintness
Jumping vision *with walking or riding on a bumpy road*	Tilting side (LEFT, RIGHT or BOTH)

Are these discrete episodes of dizziness? **If so, how long do they last when they occur** (seconds, minutes, hours, days)? **What is the frequency** (daily, weekly, monthly, etc.)? **How many episodes/attacks have you experienced total?** **Are the episodes brought on by (circle those that apply):** lifting chin up, bending down, rolling over in bed (to the LEFT or the RIGHT), going from laying to seated or seated to laying, standing up quickly without head movements	**Are the symptoms continuous?** **If so, since when?**

Can any of the following exacerbate (if you are experiencing continuous symptoms) or cause (if you are experiencing episodic symptoms) your typical spells (circle any that apply)?

Rapid head movements in any direction
Walking in the dark
Walking on uneven surfaces (e.g., grass, sand)
Car travel
Loud noises, coughing, blowing your nose, sneezing, straining or laughing (circle only the ones that apply)
Moving environment (e.g., looking at cars move)
Complex visual environments: busy grocery or department stores, crowds, 3D movies, big screen TV
Missing meals
Certain foods (which ones?) _____
Anxiety or stress
Menstruation

Do you hear internal noises that you had not heard in the past (circle any that apply)?

Hearing your eyes move (LEFT, RIGHT or BOTH ears)
Hearing your heartbeat (LEFT, RIGHT or BOTH ears)
Hearing your footsteps (LEFT, RIGHT or BOTH ears)
Does your own voice sounds louder in LEFT or RIGHT ear?

***Before, during or after you experience your typical dizzy symptoms*, do you notice (circle all that apply)?**

Headache	Nausea	Palpitations	Fullness in the ears (LEFT, RIGHT or BOTH ears)
Sensitivity to light	Vomiting	Shortness of breath	Ringing in the ears (LEFT, RIGHT or BOTH ears)
Sensitivity to sound	Seeing zig zag lines	Chest pain	Change in hearing (LEFT, RIGHT or BOTH ears)

Have you experienced any of the following (circle any that apply)?

Slurred speech
Difficulty swallowing (solids or liquids)
Room tilting
Loss of consciousness
Severe head or neck pain
Weakness (specify body part) _____
Numbness (specify body part) _____
Loss of vision in one or both eyes

Episodes of dropping to the ground as if you're being thrown/pushed to the ground

Double vision (horizontal, vertical or diagonal; resolves with closing either eye YES/NO; worse with head tilt to LEFT/RIGHT, worse with looking DOWN, LEFT or RIGHT? _____ date of onset: _____, evaluated by ophthalmology, neuro-ophthalmology or neurology with which diagnosis? _____).

EYES: Do you have any eye conditions, or have you had eye surgeries (circle all that apply)?

Glaucoma _____ Cataracts that are causing symptoms _____Cataract surgery_____
Retinal issues (please explain): _____
Optic nerve issues please explain: _____
Other: _____

Do you wear glasses (circle all that apply)? bifocals, trifocals, progressives, distance, reading

EARS: Have you experienced any of the following (circle all that apply)?

Difficulty with hearing (if so, which ear? _____when it started? _____
sudden or gradual onset _____hearing aids? _____ cochlear implant? _____)
Ear fullness or pressure
Ringing in the ears (if so, which ear _____, is it continuous or intermittent?
Is ringing synchronous with your heartbeat? Yes___ No____ High or low frequency?
Is there history of noise exposure (provide detail)? _____

HEADACHES: Have you ever (even early in life) had bad headaches? Yes___ No___

At what age did the headaches start? **How many days per month do you have any kind of headache currently? _____**/30 days. **Have your headaches ever lasted for over 4 hours?_____If not then how long?_____** **Is there a family history of bad headaches or migraines? Who? _____** **Do dizziness and headaches occur together? If so, how often (e.g., 50% of the time) ____** **Is there a personal history of motion sensitivity** (e.g., car sickness, intolerance of amusement park rides, inability to read in a car)?	**Have any of your headaches (now or previously) been associated with any of the following features?** Usually located on one side of the head Located on both sides of the head simultaneously Pulsating, throbbing, pounding quality Moderate to severe in intensity Aggravated by routine physical activity Improved when laying down in a dark, quiet room Improved by sleeping/napping Nausea Vomiting Sensitive to lights (can't go outside on a bright, sunny day) Sensitive to sounds (have to turn off music, noises) Flashing lights Zig zag lines Other visual phenomena _____ Positional? _____ In the mornings or later in the day _____
Please list medications tried to treat migraines. Include failed regimens, doses, and reasons for stopping.	**Can headaches be triggered by any of the following (circle all that apply)?** Poor sleep Stress Weather changes Menstrual cycle Other: _____ Caffeine Chocolate MSG Aged or ripened cheeses Red wine (or other alcohol)

Do you have (circle all that apply)? depression, stress, anxiety, panic attacks. **Have you been treated by a psychiatrist (for what)?** _____

Have you been diagnosed with any of the following (circle all that apply)? syphilis, Lyme disease, sarcoidosis, meningitis or encephalitis

Have you ever suffered injury to or surgery to?

Ears: _____
Eyes: _____
Head: _____
Neck: _____

Have you had any of the following (please describe)?

Difficulty with sleep onset: _____
Difficulty with sleep maintenance: _____
Do you snore? ____ Do you wake up refreshed in the mornings? _____
Tremor: _____

Family history of (circle all that apply and provide details):

A similar condition to yours	Migraine	Meniere's syndrome
Hearing loss early in age	Vertigo or dizziness	Balance issues

Do you consume red meat? _____

Aside from what has been discussed above, do you have any other medical problems (please explain)?

Eyes: _____
Ears, Nose, or Throat: _____
Heart: _____
Lungs: _____
Gastrointestinal system (e.g., bowel issues): _____
Genitourinary system (e.g., bladder issues): _____
Skin: _____
Musculoskeletal (e.g., issues with bones, joints, muscles): _____

Please provide a writing sample if the rest of this questionnaire was not filled out by you:

_____

DOCTORS WHO YOU WOULD LIKE THIS NOTE SENT TO (please provide addresses and fax numbers):

Primary Care:

Others: