Memphis Speech and Hearing Center
Vestibular Case History Form

Name: ____

ONSET
Briefly describe what happened the first time you experienced an episode of dizziness or imbalance:
____
____
____

HISTORY
When did your problem start? _________________________
Was it associated with a relative event (i.e. head injury, illness, etc.)? Y / N
If yes, explain: ____

Was symptom onset: ☐ Gradual ☐ Sudden ☐ Overnight ☐ Other
If "Other", please describe: ____

Are symptoms constant or variable? _________________________
If variable:
a. Spells occur every (# of) _____ hours _____ days ______ weeks ______ months _____ years
b. Spells last: ☐ Seconds ☐ Minutes ☐ Hours ☐ Days
c. Do you have any warning signs that a spell is about to happen? Y / N
d. Are you completely symptom free between spells? Y / N

Do symptoms occur when changing positions? Y / N
If yes, check all that apply:

☐	Position	☐	Position
	Rolling over to the left (in bed)		Rolling over to the right (in bed)
	Moving from a lying to a sitting position		Looking up with your head back
	Turning head side to side while standing		Bending over with your head down

Does anything make your symptoms **better**? Y / N
If yes, explain: ____
Does anything make your symptoms **worse**? Y / N
If yes, check all that apply:

☐	Activity/ Situation	☐	Activity/ Situation
	Moving my head		Physical activity or exercise
	Riding or driving in the car		Large crowds or busy places
	Loud sounds		Coughing, straining, and/or blowing my nose
	Standing up		Eating certain foods
	Time of day		Menstrual periods
	Stress/anxiety/mental health issues		Other:

When you have symptoms, do you feel the need to support yourself to stand and/or walk? Y / N
Do you experience motion, air, or car sickness? Y / N

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Did you experience motion, air, or car sickness as a child? Y / N

When walking, you: ☐ Remain in a straight path ☐ Veer left ☐ Veer right

Have you ever fallen as a result of your problem? Y / N

If yes:

How many times? __________ Where? __________________________________

When was your most recent fall? ____

Do you have any associated ear symptoms? Y / N

If yes, please check the symptom and circle which ear is affected:

☐	Symptom	Circle which ear is affected		
	Hearing difficulty	Both	Left	Right
	Noises in the ear	Both	Left	Right
	Ear pressure/ fullness	Both	Left	Right
	Ear drainage	Both	Left	Right
	Ear pain	Both	Left	Right
	History of noise exposure	Both	Left	Right
	Perforated eardrum	Both	Left	Right

When dizzy, do you experience:

Lightheadedness or a floating sensation?	Yes	No
Objects or your environment turning around you?	Yes	No
A sensation that you are turning or spinning while the environment remains stable?	Yes	No
Nausea or vomiting?	Yes	No
Tingling in your hands, feet, or lips?	Yes	No

Do you ever experience:

☐ Slurred speech ☐ Difficulty swallowing ☐ Double or blurry vision ☐ Facial tingling/ numbness

Have you ever been exposed to any solvents, chemicals, etc.? Y / N

Have you ever been diagnosed with a traumatic brain injury (TBI)? Y / N

Have you seen other healthcare providers for your condition? Y / N

If yes, who?

☐ Family Doctor ☐ ENT Specialist ☐ Neurologist ☐ Cardiologist ☐ Emergency Room Doctor ☐ Other: ____________________________________

Is there there anything else you would like to tell your audiologist about your dizziness?

____

____

____

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MEDICAL HISTORY

Please check all that apply:

✓	**Condition**	✓	**Condition**
	Parkinson's Disease		Depression
	Chronic Fatigue		Loss of limb (arm, leg)
	Multiple Sclerosis		Osteoporosis
	Migraines		Headaches
	Ulcer		Memory Loss
	High Blood Pressure		Anemia
	Thyroid Disease		Sinusitis
	Tumor or Cancer		Asthma/ Allergies
	Circulation Problems		Head or Neck Injury
	Diabetes		Vision Problems/ Eye Disorders
	Stroke		Seizures/ Convulsions
	Heart Attack/ Heart Disease		Pulmonary/ Respiratory Problems
	Arthritis		Hip or Leg Problems
	Glaucoma		Cataracts
	Macular Degeneration		Back Problems
	Other:		Other:

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Important Information About Your Upcoming Appointment

- Follow instructions from your referring physician for taking medications before your appointment. Medications given for dizziness may influence the test. Contact your physician before stopping any medications.
- Memphis Speech and Hearing Center is located at the intersection of Park Ave and Goodlett St in the Community Health Building, 4055 N Park Loop, Memphis TN 38152.
- Patient parking is available out front and on the west side of the building, including handicap spaces. Please park in a reserved space with a blue and white sign labeled, "MSHC Client Parking Only". Place your parking pass on the dashboard (included in received paperwork, or available at the clinic front desk).
- You should have received paperwork in the mail. Please complete all paperwork and bring it to the appointment. If you have not received or finished your paperwork on the date of your appointment, arrive 30 minutes early to complete it.
- Bring a complete, current medications list to your appointment.
- This appointment may take up to three hours, depending on what your physician has ordered. Please arrive on time so all tests can be completed.
- For your comfort, we recommend you do not eat for at least 4 hours prior to your scheduled appointment time.
  If you are diabetic, eat lightly to maintain blood sugar levels. You may also want to bring a snack.
- Refrain from wearing makeup on the day of the appointment, including eye makeup.

If you have any further questions, please contact Memphis Speech and Hearing Center at (901) 678-2009. We look forward to seeing you!