MERCYHEALTH

Mercy-Tiffin Rehabilitation and Therapy
Vestibular Rehab Services Patient History Questionnaire

In order for us to fully address all aspects of your problem, the following information is needed. Please take time to complete this form. Feel free to ask for assistance or clarification. Thank you!

NAME:_____ DATE:_____

1. Please describe the reason you are seeing us:_____
_____

2. Please mark any symptoms that you have:

☐ Poor Balance	☐ Shortness of Breath
☐ Trouble Walking	☐ Difficulty Concentrating
☐ Falls	☐ Fear of Falling
☐ Sensation of Spinning	☐ Sensation of being pushed of pulled to one side
☐ A Tilting Sensation	☐ Light Headed
☐ Fainting	☐ Floating
☐ Swimming	☐ Rocking
☐ Fear of crowds or busy Places	☐ Queasiness
☐ Nausea/Vomiting	☐ Sweating

3. When did your symptoms begin?_____

4. Was the first episode sudden or gradual?_____

5. Do you know anything that might be related or have caused your symptoms?_____

6. Are your symptoms brought on or made worse by changes in position or movements? If yes, please describe:_____

7. How long does an attack usually last?_____

8. Rate your symptoms on a scale of 0-10 (0=no symptom and 10= worst):_____

EAR SYMPTOMS:

1. Do you have hearing loss?	☐ Yes	☐ No
2. Does your hearing fluctuate?	☐ Yes	☐ No
3. Do you have pain in your ears?	☐ Yes	☐ No
4. Do your ears have a feeling of pressure of fullness?	☐ Yes	☐ No
5. Do you have a history of ear infections?	☐ Yes	☐ No
6. Do you wear hearing aids?	☐ yes	☐ No

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FUCNTION

1. Do you live alone? ☐ Yes ☐ No
   If NO, with whom do you live?_____
2. Do you have steps to climb? ☐ Yes-How many?_____ ☐ No
3. Do you have railings on Steps? ☐ Yes ☐ No
4. Are you employed? ☐ Yes ☐ No
5. Are you off work due to this condition? ☐ Yes-How long?_____ ☐ No
6. Have you fallen in the past year? ☐ Yes-How many times?_____ ☐ No
7. Have you had any near falls in the last year? ☐ Yes-How many times?_____ ☐ No
8. Are you able to drive? ☐ Yes ☐ No
9. Do you exercise? ☐ Yes ☐ No
10. Do you have pain? ☐ Yes ☐ No
    Please rate your pain on a 0-10 scale (0=no pain and 10=most severe)_____
11. What are your goals for Physical Therapy?_____

_____

_____

MEDICAL HISTORY

1. Have you had, or do you currently have, any of the following listed conditions?

☐ High Blood Pressure	☐ heart Problems	☐ Pacemaker
☐ Panic Attacks or Anxiety	☐ Stroke	☐ Diabetes
☐ Gland Problems (thyroid)	☐ Arthritis	☐ Low Blood Pressure
☐ Cancer	☐ Lung Disease	☐ Circulation Problems
☐ Vision Problems	☐ Hearing Problems	☐ Stomach Problems
☐ Seizures	☐ Blood Disorder/Sickle Cell	☐ Depression
☐ Kidney/Bladder Control Problems	☐ Asthma/Emphysema	☐ Lupus
☐ Current Smoker	☐ Breathing Problems	☐ Migraine Headaches
☐ Ear Surgery	☐ Pain in back of jaw/TMJ	☐ Injuries/trauma
☐ Padget's Disease		

Drink Alcohol: ☐ None ☐ Occasionally ☐ Often

Other:_____

_____

_____

2. Please list type and year of any surgeries you have had:_____

_____

3. Please list any medications or herbal remedies you are currently taking:_____

_____

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4. Have you had:

Hearing Test	☐ Yes	When_____	Result_____
Evaluation by a Neurologist	☐ Yes	When_____	Result_____
Evaluation by an ENT	☐ Yes	When_____	Result_____
Evaluation by an Eye Doctor	☐ Yes	When_____	Result_____
Caloric test (water or air in ear)	☐ Yes	When_____	Result_____
MRI (with Dye)	☐ Yes	When_____	Result_____

5. is there a chance you might be pregnant? ☐ Yes ☐ No

6. Are there any additional issues or concerns that you would like your therapist to be aware of?

_____
_____
_____
_____

Next Doctor's Appointment:_____

Please keep us updated on the date of your next doctor's appointment throughout your treatment program.

Thank you!

_____ _____

Signature **Date**

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DIZZINESS HANDICAP INVENTORY

The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness. Please mark "always," "sometimes," or "no" to each question. **Answer each question as it pertains to you dizziness or balance problem only.**

	ALWAYS	SOMETIMES	NO
P1. Does looking up increase your problem?			
E2. Because of your problem, do you feel frustrated?			
F3. Because of your problem, do you restrict your travel for business or recreation?			
P4. Does walking down the aisle of a supermarket increase your problem?			
F5. Because of your problem, do you have difficulty getting into or out of bed?			
F6. Does your problem significantly restrict your participation in social activities such as going out to dinner, going to the movies, dancing, or to parties?			
F7. Because of your problem, do you have difficulty reading?			
P8. Does performing more ambitious activities like sports, dancing, household chores such as sweeping or putting away dishes increase your problem?			
E9. Because of your problem, are you afraid to leave your home without someone to accompany you?			
E10. Because of your problem, have you been embarrassed in front of others?			
P11. Do quick movements of your head increase your problem?			
F12. Because of your problem, do you avoid heights?			
P13. Does turning over in bed increase your problems?			
F14. Because of your problem, is it difficult for you to do strenuous housework or yard work?			
E15. Because of your problem, are you afraid people might think you are intoxicated?			
F16 Because of your problem, is it difficult for you to go for a walk by yourself?			
P17. Does walking down a sidewalk increase your problem?			

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E18. Because of your problem, is it difficult for you to concentrate?			
F19. Because of your problem, is it difficult for you to walk around the house in the dark?			
E20. Because of your problem, are you afraid to stay home alone?			
E21. Because of your problem, do you feel handicapped?			
E22. has your problem placed stress on your relationships with members of your family or friends?			
E23. Because of your problem, are you depressed?			
F24. Does your problem interfere with your job or household responsibilities?			
P25. Does bending over increase your problem?			