Avenue DIZZINESS & BALANCE Clinic

Vertigo Patient Intake Form

Date:

Name: OHIP:

D.O.B.: Gender:

Please try to answer all of the questions. Choose yes or no and fill in the blank spaces.

What are the reasons for your visit?

_____

_____

_____

1. Your dizziness is?

☐ Constant ☐ Frequent ☐ Intermittent

☐ Regular ☐ Sudden ☐ Unpredictable

a. When did dizziness first occur (very first episode)? _____

b. How often do you experience it? _____

c. How long do the episodes last? _____

d. When was the last experience? _____

e. Do you have any warning that the dizziness is about to start? ☐ Yes ☐ No

f. Do they occur at any particular time of day or night? ☐ Yes ☐ No

g. Do you feel normal in between dizziness? ☐ Yes ☐ No

h. Does changing of position make you dizzy? ☐ Yes ☐ No

2. Do you know of anything that will…

a. Stop your dizziness or make it better? ☐ Yes ☐ No

if yes, please describe: _____

_____

b. Make your dizziness worse? ☐ Yes ☐ No

if yes, please describe: _____

_____

c. Triggers your dizziness? ☐ Yes ☐ No

if yes, please describe: _____

_____

3. When you are "dizzy" do you experience any of the following sensations?
Please read the entire list, check the boxes that describe your feelings most accurately.

a. Light headedness or swimming sensation in the head? ☐ Yes ☐ No

b. Near blacking out or loss of consciousness? ☐ Yes ☐ No

c. Tendency to fall?

☐ Backward ☐ Forward ☐ To the right ☐ To the left ☐ No

d. Objects spinning or turning around you? ☐ Yes ☐ No

e. Sensation that you are spinning inside, with outside objects remaining stationary? ☐ Yes ☐ No

f. Loss of balance when walking? ☐ Yes ☐ No

g. Headache? ☐ Yes ☐ No

h. Nausea or vomiting? ☐ Yes ☐ No

4. Do you have any of the following ear symptoms?

a. Difficulty in hearing? ☐No ☐Left ear ☐Right ear ☐Both ears

b. Stuffiness or pressure in ears? ☐No ☐Left ear ☐Right ear ☐Both ears

c. Pain in ears? ☐No ☐Left ear ☐Right ear ☐Both ears

d. Fluid from ears? ☐No ☐Left ear ☐Right ear ☐Both ears

e. Noise in ears or head? ☐No ☐Head ☐Left ear ☐Right ear ☐Both ears

5. Have you ever experienced any of the following symptoms?

a. Double, blurred or loss of vision? ☐No ☐Constant ☐Intermittent

b. Numbness of face, arms or legs? ☐No ☐Constant ☐Intermittent

c. Weakness in arms or legs? ☐No ☐Constant ☐Intermittent

d. Clumsiness in arms or legs? ☐No ☐Constant ☐Intermittent

e. Confusion or loss of consciousness? ☐No ☐Constant ☐Intermittent

f. Difficulty with speech? ☐No ☐Constant ☐Intermittent

g. Difficulty with swallowing? ☐No ☐Constant ☐Intermittent

h. Pain in neck or shoulder? ☐No ☐Constant ☐Intermittent

6. Medical – Social Questions:

a. Do you have low or high blood pressure? ☐ Yes ☐ No

b. Do you have diabetes? ☐ Yes ☐ No

c. Do you have low iron levels? ☐ Yes ☐ No

d. Do you have low blood count? ☐ Yes ☐ No

e. Do you have a history of stroke? ☐ Yes ☐ No

f. Do you have a history of heart attack? ☐ Yes ☐ No

g. Have you been on any medications to help the dizziness? ☐ Yes ☐ No

Name of medication: _____

_____

_____

Did they help? ☐ Yes ☐ No

7. Please check the following that applies:

☐ Previous ear surgery

☐ Previous ear trauma

☐ Thyroid problems

☐ Tobacco in any form

☐ Trouble with vision

8. Family History:

☐ Hearing loss

☐ History of autoimmune diseases

☐ Vertigo

9. Please list all evaluations and/or treatments (Including hearing test, ENG test, MRI, CT scan, etc.) you have had for your vertigo:

MRI? ☐ Yes ☐ No
If you had MRI done, when and where you had it done? what was the evaluation(s)?

_____

_____

_____

CT? ☐ Yes ☐ No
If you had CT done, when and where you had it done? what was the evaluation(s)?

_____

_____

_____

ENG? ☐ Yes ☐ No
If you had ENG done, where you had it done? when? and what was the evaluation(s)?

_____

_____

_____

Hearing test? ☐ Yes ☐ No
If you had hearing test done, when and where you had it done? what was the evaluation(s)?

_____

_____

10. What other medications have you tried in the past for vertigo relief?
(in the following format: Medication? Dose? How often? Does it help? Doctor?)

_____

_____

_____

_____

11. Please list all other medications you currently take:
(in the following format: Medication? Dose? How often? Length of time taking? Maintenance or short term? Does it help? Doctor?)

_____

_____

_____

_____

12. Are you on ODSP or WSIB due to vertigo?

☐ ODSP (Ontario Disability Support Program)

☐ WSIB (Workplace Safety and Insurance Board)

☐ None of the above

13. Do you drive or operate heavy machinery?

☐ Yes ☐ No

14. History of Noise Exposure? ☐ Yes ☐ No