

BALANCE AND VESTIBULAR SERVICES AT LEE MEMORIAL HEALTH SYSTEM

We would like to welcome you to our facility. In order to make your initial visit efficient we are asking that you take the time to fill out the following paperwork as thoroughly as possible. We look forward to seeing you!

YOUR APPOINTMENT DATE/TIME: _____

PLEASE ARRIVE 15 MINUTES EARLY TO ALLOW US TO GET YOU CHECKED IN.

Name: _____ **Age:** _____ **Name Preference:** _____

Referring Physician: _____ **Primary Care Physician:** _____

Care from other Physicians / Healthcare Providers: _____

If you would like a copy of your report to be sent to another physician besides your referring physician, please sign here: _____

Provide Physician Name: _____ Fax Number: _____

Social History: Single Married Divorced Widowed Separated Significant Other

Who will be helping at home: _____

If alone, do you have family local and/or daily verbal contact with someone? No Yes

If **Yes**, who: _____

Do you smoke? Yes No Do you drink alcohol? Yes No Do you snore? Yes No

Primary Contact Person: _____ **Relationship:** _____ **Phone:** _____

Primary Language: English Spanish Other: _____

Present Level of Activity/Hobbies: _____

Any activity you have stopped doing because of your problem? _____

Are you Driving: Yes No; check reason: No Reason No License Medication Illness Fear
 Doctor Orders Family Request Other: _____

Handicapped Sticker? Yes No

Employment Status: Retired: When: _____ Occupation: _____

Employed: Occupation: _____

Off work because of current episode? No Yes, since: _____

HOME ENVIRONMENT

Full-Time Florida Resident: Yes No, only in FL # _____ months What is the other state: _____ Leaving FL: _____

Dwelling: House Condo Apartment Mobile Home
 Trailer Home Boat Other: _____

Steps: To enter: _____ Within home: _____ Rails: Right Left None

Pet(s): _____

Home Adaptive Equipment: Ramp Grab Bars in shower / by toilet / other: _____ 3 in 1 toilet
 Raised Toilet Seat Urinal Shower Seat Hospital Bed
 Automatic Bed Lift Chair Night Lights Lifeline
 Other: _____

Equipment: That you have and use: _____

Available equipment at home that you do not use: _____

SERVICES THAT YOU USE FROM THE COMMUNITY:

Food Services Cleaning Transportation Activities of daily living, such as grooming, bathing, dressing, etc.

Other: _____

LEE MEMORIAL HEALTH SYSTEM

Lee County, Florida

BALANCE/VESTIBULAR HEALTH HISTORY

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UCO TAB - HISTORY & PHYSICAL

PAST MEDICAL HISTORY (MARK "X" FOR ALL THAT APPLY)

CARDIAC:	<input type="checkbox"/> Heart Disease <input type="checkbox"/> Pacemaker	<input type="checkbox"/> Heart Attack <input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Heart Failure <input type="checkbox"/> Orthostatic Hypotension	<input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Angina
RESPIRATORY:	<input type="checkbox"/> Short of Breath <input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema <input type="checkbox"/> Productive Cough	<input type="checkbox"/> Allergies <input type="checkbox"/> Sleep Apnea	
NEUROLOGICAL:	<input type="checkbox"/> Headaches <input type="checkbox"/> Back Problems <input type="checkbox"/> Peripheral Neuropathy	<input type="checkbox"/> Seizures <input type="checkbox"/> Acoustic Neuroma <input type="checkbox"/> Numbness in Face	<input type="checkbox"/> Stroke <input type="checkbox"/> Fainting Episodes <input type="checkbox"/> Whiplash	<input type="checkbox"/> Head Injury <input type="checkbox"/> Migraine <input type="checkbox"/> Weakness or Paralysis in Face
PSYCHOLOGICAL:	<input type="checkbox"/> Depression	<input type="checkbox"/> Psych. Hospitalization	<input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Suicide Gesture
INFECTIOUS DISEASE:	<input type="checkbox"/> HIV	<input type="checkbox"/> TB	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Nightsweats
GASTROINTESTINAL:	<input type="checkbox"/> Reflux Disease	<input type="checkbox"/> Liver Problems	<input type="checkbox"/> Weight Loss/Gain	<input type="checkbox"/> Pancreatitis
ENDOCRINE:	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid Problems		
GU / GYN:	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> GU Problems	<input type="checkbox"/> Pregnant	<input type="checkbox"/> GYN Problems
CANCER:	<input type="checkbox"/> Cancer <input type="checkbox"/> Family History	<input type="checkbox"/> Chemotherapy <input type="checkbox"/> Stem Cell	<input type="checkbox"/> Radiation	
MISCELLANEOUS:	<input type="checkbox"/> Arthritis <input type="checkbox"/> Ear Surgery <input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Blood Transfusion <input type="checkbox"/> Ear Trauma <input type="checkbox"/> Motion Sickness	<input type="checkbox"/> Blood Reaction <input type="checkbox"/> Meniere's <input type="checkbox"/> Prolonged IV Antibiotic Treatment	<input type="checkbox"/> Street/Rec Drugs <input type="checkbox"/> Osteoporosis

REVIEW OF MEDICATIONS / HEALTH HISTORY

Medication related to management of vertigo/balance symptoms:

Antivert (Meclizine) No Yes: _____
 Bonine No Yes: _____
 Dramamine No Yes: _____
 Scopolomine No Yes: _____
 Valium No Yes: _____
 Other: _____

<input type="checkbox"/> None	MEDICATIONS (Prescriptions & over the counter)		<input type="checkbox"/> See Attached List
MEDICATION	REASON FOR USE	MEDICATION	REASON FOR USE

<input type="checkbox"/> None	SURGERIES / PROCEDURES		<input type="checkbox"/> See Attached List
SURGERIES/PROCEDURES	DATE	SURGERIES/PROCEDURES	DATE

Allergies: Drug: _____
 Latex: Yes No Other: _____

Vision Last Vision Test: _____ Last Eye Glass Prescription Change: _____
 Glasses: Reading Distance Progressive Prism Bifocals Trifocals Contacts Implants
 Blindspots Blindness: . . . Left Right Both Blurred Vision: Left Right Both
 Diabetic Retinopathy: . . . Left Right Both Glaucoma: Left Right Both
 Macular Degeneration: . . Left Right Both Double Vision: Horizontal Vertical
 Cataracts: Left Right Both If yes: Constant Intermittent

Hearing Last Hearing Test: _____ Any Hearing Aids: R L
 Hearing Loss No Yes: R L; If yes: Sudden Gradual
 Ear Pain No Yes: R L
 Ear Pressure No Yes: R L
 Ear Fullness No Yes: R L
 Ear Discharge No Yes: R L
 Ear Wax No Yes: R L
 Tinnitus (ringing in the ears) . . . No Yes: R L
 Ear Infection No Yes: R L

Recent Medical Tests: MRI _____ ENG/VNG _____ Doppler (carotid or legs) _____
 If box is checked, please EMG _____ Blood Tests _____ Nerve Conduction Studies _____
 indicated date of last test on CT Scan _____ X Ray _____ Magnetic Resonance Angiography (MRA) _____
 the line provided.

HISTORY OF PRESENT ILLNESS

Chief Complaint / Symptoms:

- Loss of Balance while Standing Still
- Loss of Balance with Walking
- Veering during Walking
- Unsure on feet
- Falling
- Near Falls
- Fear of Falling indoors 0-10: ___/10 (worst)
- Fear of Falling outdoors 0-10: ___/10 (worst)
- Dizziness
- Lightheadedness
- Vertigo/Spinning
- Nausea
- Near fainting
- Black Out
- Vomiting
- Floating in head
- Pressure in head
- Migraines
- Headaches
- Difficulty concentrating
- Anxiety
- Giddiness
- Confusion
- Difficulty word finding
- Tingling
- Numbness
- Pain
- Clumsiness
- Problems with neck
- Neck pain
- Difficulty reading
- Difficulty focusing eyes
- Difficulty with computer screens
- Blurry Vision
- Double Vision
- Motion Sickness
- Other(s): _____

Symptoms: Present since: _____ Worsening Improving No Change

Onset: Gradual Sudden No Known Cause Specific Incident: _____

Most Recent Attack: _____

Symptoms: Constant Intermittent - Lasting: Seconds: _____ Minutes: _____ Hours: _____ Days: _____

Any previous treatments for present condition? No Yes: _____

Any recent hospitalization? No Yes: _____

Precipitating Factors / Symptoms Brought on by:

- Standing up from sitting
- Eye movements
- Movement of surroundings
- Riding in an elevator
- Riding Up / Down escalator
- Quick head movements
- Walking on uneven surfaces
- Riding in a car
- Being in Grocery Store
- Being in Shopping Mall
- Being in a crowd
- Reading
- Using computer
- Watching TV
- Lights
- Noise
- Fatigue
- Insomnia
- Anxiety
- Exertion
- Stress
- Prolonged sitting
- Coughing/Sneezing
- Blood Sugar increase / decrease
- Blood Pressure Changes increase / decrease
- Poor Eating Habits
- Hunger
- Alcohol
- Menstrual Cycle
- Lying down in bed
- Rolling in bed
- Getting up to sit from bed
- Looking up
- Bending over
- Turning Quickly
- Being in the dark
- Other(s): _____

What Makes Symptoms Better?

- Staying Still
- Lying Down
- Sleeping
- Sitting
- Closing Eyes
- Medication
- Activity
- Alcohol
- Eating
- Relaxation Techniques
- Nothing
- Other: _____

Have you had any falls in the last year? Yes, how many in the past 12 months? _____ No

Date of Last Fall? _____ Any major injuries? _____ Did you seek medical assistance? Yes No

I have had near falls: Daily Weekly Monthly No falls or near falls

Do you have pain now? Yes No IF YOU ANSWERED YES, PLEASE COMPLETE THE FOLLOWING:

Where is your pain located? _____

What makes your pain feel better? _____

What makes it worse? _____

On a scale of 0-10 with 0 being no pain and 10 being the greatest amount possible, how intense is the pain now? _____

THANK YOU FOR YOUR THOROUGHNESS. WE LOOK FORWARD TO SEEING YOU!
STOP! THERAPY STAFF WILL COMPLETE THIS SECTION

Nutritional Needs Addressed? Yes No Comments: _____

Learning Preferences: Visual Demonstration Verbal Comments: _____

Education Barriers: None Non-English speaking Non-Communicative Behavior HOH _____

Discharge Planning/Educational Needs: _____

I have reviewed this form and will update the information as changes occur.

THERAPIST SIGNATURE: _____ **DATE:** _____ **LICENSE #:** _____